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Abstract

Nursing as a profession is mandated to provide culturally competent care to clients in increasingly multicultural settings. Understanding of what comprises culturally competent care in nursing varies widely. The purpose of this study was to explore the nature of intercultural dialogue through careful attention to conversational dialogues between nurses and patients from different cultures.

Hermeneutic methodology was used as a way to explore intercultural dialogue as it calls us to understand something for all sides and shared understanding emerges. Ten audiotaped conversations were held; seven with a nurse in West Africa and three with a Multicultural Health Broker in Canada.

Four major themes emerged from the conversation data: The embodied experience of life, Money makes the world go around, Cultural strength, and Education: investing in the future. Intercultural dialogue is complex and difficult, requiring respect, commitment, acknowledgement of power differentials, and face-to-face engagement in the process of learning about oneself and others.

Through intercultural dialogue respectful relationships can be developed in which shared understanding emerges. It is hoped that the findings in this initial study on intercultural dialogue will help to inform nursing education and practice and lead to further study about dialogue, as well as the components of intercultural dialogue identified in this study.

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CHAPTER 1: BEGINNINGS

Throughout my nursing career I have encountered patients from diverse ethnic and religious backgrounds. Always in these situations I questioned my ability to care for these "others." How could I truly care for them if I had no understanding of their experiences in the world and what those experiences meant to them? No doubt I provided care according to what I knew to be good, competent care and no doubt they obligingly accepted my care. They were in my world. However, I always felt a need to traverse the gap between our different worldviews, to learn about and appreciate our differences and similarities. I was drawn to understand their world and understand how they viewed my world.

Many years later as part of an undergraduate BScN clinical experience I seized the opportunity to experience nursing and health care in Ghana, West Africa. Here I was, the stranger in another's world. As a nurse who was once again a student, I was involved in authentic, personal interaction with clients and health care providers. I constantly questioned my role and my approach as the stranger in another's world. As I observed, participated and learned more, I began to examine and question my own values, beliefs; my whole culture really. I found I could no longer tolerate the comfort and ease of hiding behind my white North American dominance and I became disturbed by global issues affecting the health and welfare of all the world's people. I experienced dissonance in myself. Simply by virtue of being a North American in Ghana, I was ascribed a status I had not earned. It didn't seem right to me. But more so than that, was my nursing self, as nursing in its nature forms close and meaningful relations with others. Was I enacting

my nursing relation in a respectful way? How did I deal with the power imbalances that I knew about and those hidden ones I could not even imagine, being in a different culture? What were the social, health and economic issues embedded in these interactions, influencing the direction of not only what the person revealed to me but also, how I responded? Did I respond appropriately given these enormous considerations? Did I cause harm, was I helpful? What is appropriate and necessary in these interactions? As Bergum (1994) writes, ethical questions are about "how one should act", and deciding "what is the right thing to do?" I had a need to understand my experiences in Ghana.

Upon my return from Ghana and the pursuit of graduate education, I had the opportunity to more deeply explore intercultural dialogue and the related issues of respect, globalization and power. It was an opportunity to review my past experiences, extend my current understanding, and to acknowledge the need to learn more. While the nursing cultural literature formed a foundation for my pursuit of knowledge, I missed the authenticity of interacting within the context of the people's lives. I missed Ghana. I missed all it held for me; its richness, its extremes of health and illness, its beautiful humanity given its scarce resources, its great potential to call out of me who I am and question who I am in relation with others. To return and understand would become my passion.

In discussion with my thesis committee about such topics; I decided to look at my nursing experiences in Ghana, review my journal entries, and examine the themes and questions that presented themselves upon reflection. These themes and questions remain with me and I present them below. I was drawn to Dillon's work on the meaning of

respect; I have to "look again"(Dillon, 1992). Within me was a strong sense that no amount of literature could answer the kinds of questions that surrounded me at this time.

Intercultural dialogue

Intercultural communication on a global level involves interactions steeped in power and dominance. As power is an integral part of human interaction, intercultural communication as a form of social interaction between humans necessarily involves power. In such communication, people respond to each other and act upon their worlds (Shi-Xu & Wilson, 2001).

According to Barrera and Corso (2002), diversity is a relational and context-embedded reality. Cultural diversity should be seen as a positive entity where positive or negative consequences are related to individual or institutional responses to that diversity. Through dialogue we have the opportunity to explore the meanings we attribute to diversity without concentrating on the diversity itself (Barrera & Corso, 2002). In dialogue we must own our own identity in difference. When we are responsible for our own identity, the threat of difference of another becomes an opportunity for growth, enrichment and mutuality and less of a threat to our own identity (Olthius, 2000).

Shi-Xu & Wilson (2001) present two foundational concepts in intercultural communication; competence and misunderstanding. Competence refers to the actual knowledge and skills of another's language and culture. Misunderstanding refers to the incorrect mental representation of the intended meaning of a message due to one's own cultural perspective. To further expand on competence in cultural communication, Barrera and Corso (2002) explain that the key to cultural competence lies in our ability to

involve ourselves in reciprocal, responsive and respectful interactions across diverse cultural parameters. In culturally diverse situations, we are challenged to recognize that a person is always more than and sometimes radically different from our preconceived ideas about whom they are. We must be mindful in dialogue, not to reduce reality to a limited space (Barrera & Corso, 2002).

Reciprocity in interactions refers to power. Commonly power is defined as expertise and authority, and less commonly as capacity or capability. Being reciprocal is to acknowledge and trust that the experiences and perceptions of every individual in an interaction are of equal value to that interaction (Barrera & Corso, 2002). Responsive interactions require an openness to allowing others to uncover who they are rather than us shaping them into what we want them or need them to be (Freedman & Combs, 1996 cited in Barrera & Corso, 2002). Respectful interactions require that we understand how another's behavior makes sense from their cultural and personal perspectives. In dialogue we work towards entering the third space, where differences are understood to be complimentary (Barrera & Corso, 2002). This space is also referred to as the relational space where we commit to learning to understand each other (Bergum, 1994). One must be willing and able to stay with the tension of contradiction or difference, holding divergent views in one's mind without having to force a choice between them. Existing in the relational or third space, according to Barrera and Corso is learned best through practice. Gadow (1999) explains that because a relational narrative requires and expresses engagement, it extends beyond either individual because knowledge and understanding are generated as a result of the engagement. It is more than personal but not universal as it does not extend beyond the relationship.

Roy and Starosta (2001) show us how Gadamer's critical hermeneutics can be applied to intercultural communication, by sharing the qualities required by scholars "in order to promote a human universe which abounds in contextual and individual differences" (p.16). One must be able to assimilate their own cultural traditions, without using them as a means to an end. One must desire the unfamiliar and be comfortable with such contexts, have a cosmopolitan view of the world, have engaged in a process of self-examination which is situated in the universality of the human condition and rich in diversity. Finally, one must be sensitive, tactful and open to expanding their own horizons (Roy & Starosta, 2001).

Ghana: Another knock

We hear another knock on the door. The frail tap calls out for help. The tiny cubicle of a room is dark with privacy, sweltering heat being suppressed by cool air forcing its way into being. A young man enters, his desperate eyes showing death and shame. He lowers his emaciated frame carefully onto the nearest chair. I sit beside him, in close proximity to this dying stranger. "I have been feeling sick for about a year. I can't eat, I have diarrhea and I am too weak to work. My wife has thrown me out. My friend has brought me here to see Keziah."

Coughing sends his body into spasms, each one deepening his weakness. He is unable to recall the number of women he has had sexual relations with in the last year. It is too overwhelming a number to remember. A mixed feeling of anger and compassion fill me as I try to comprehend what he has just willingly shared with us. I want to be

angry at his lack of sexual responsibility, but try to understand accepted ways. Keziah turns to me and quietly says, "What do I do with this?"

The magnitude of HIV devastation in Africa hits me like a wrecking ball and I know Keziah and I share the same feelings. We live worlds apart but not so far apart, as in our shared nursing world we experience the same thoughts and feelings. Do we share these feelings as nurses, or as women, or is it specific to the two of us in this situation right now? Keziah leaves us for a moment with her freshly drawn sample of blood.

The man and I sit alone, sharing the silence, the heat, and the crushing emotions which have filled the room. His weary head drops to his bony arms, a cushion on Keziah's desk. He is exhausted. Around him I sense an overwhelming presence of doom. He has heard of HIV/AIDS. He knows it means the end. There is no cure. Our eyes meet and I am provided with a direct, open route to his soul, as he is to mine with this profound meeting of the eyes. The seemingly hopeless void is filled with a momentary connection with him as he allows the stranger to see the regret, fear, sadness, and shame that have overtaken this life and he sees in this nurse stranger one who is endeavoring to understand his situation.

Now there is only compassion. Flowing into the space between us is merely a fraction of the heaviness he carries as he increases his understanding of the deadly consequences of his actions. His sense of grief stays with me. We are strangers momentarily connected at a level, which surpasses all potential gender and cultural barriers. I reach out and touch his arm. It is very nearly the only thing left to do. Keziah's question lingers in the heaviness. "What can I do?" I accept Keziah's question as an

invitation, a call to share in this together, the responsibility of caring, sharing the weight of the devastation. I take up the invitation without fully understanding how and why.

Seeking knowledge: The burden of HIV/AIDS

Stephen Lewis (2001) presents discouraging statistics to the world about HIV/AIDS. There are currently 36 million estimated people living with HIV/AIDS, 25.3 million of them in Africa. He lashes out at multinational pharmaceutical companies and their home governments in wealthy developed nations, for working to keep prices for anti-retrovirals high and patents protected. Poor countries can only hope to prevent future cases through prevention programs, as well as treating some opportunistic infections with less effective common drugs. HIV/AIDS is clearly a global pandemic, however access to resources to manage the pandemic is far from global. The management of the same disease has different potential due to economic status. Essentially, Lewis (2001) charges, "If you have HIV/AIDS in the North you live, in the South you die".

Despite unprecedented economic growth and advances in the areas of science, technology and health care, we experience global instability and dramatically widening disparity in wealth and health. Poor countries bare over 80% of the global burden of disease (Benetar, 2002). Poor nations lose out in international trade and foreign investment activities because the rules of the game are biased against them. With increased pressure to perform in global markets, governments are unable to subsidize health care for the poor (Velasquez & Boulet, 1999). In addressing the factors responsible for the lack of availability of anti-retroviral drugs for AIDS treatment in Africa, Attaran and Gillespie-White (2001) identify the high cost of medications, national regulatory

requirements for medicines, tariffs and taxes and a lack of international aid to fund AIDS treatment. Lewis also exposes the false and judgmental belief that people in developing nations lack the ability to follow the rigorous medication regimes required in the treatment of AIDS (Lewis, 2001). These circumstances, Lewis and others point out, while seemingly difficult and impossible, are nothing compared to the destruction of humanity that goes on right now. Is the African culture becoming increasingly identified and defined primarily through this illness?

In Jeffrey Sachs report of the Commission on macroeconomics and health, prepared for the WHO (2001), he reports that health is widely understood to be a central goal and outcome of development. However, he explains, the importance of investing in health to promote economic development and poverty reduction has been much less appreciated. It is now clear that extending crucial health services to the world's poor could save millions of lives annually, reduce poverty, spur economic development and promote global security. Macroeconomic evidence confirms that countries with the weakest conditions of health and education are less able to achieve and sustain economic growth (Sachs, 2001).

In recent decades, the idea of health as the cornerstone of economic development has been replaced by the idea that health services and public health for all are an obstacle to the wealth of nations. International finance prevails over all other interests leading to unprecedented inequalities in the world (Berlinguer, 1999). The relationship between globalization and national health is illustrated in the following example. The European Union has invested $2 million in the fight against lung cancer, while at the same time investing $2 billion to subsidize tobacco growing and exporting in Europe. The United

States has donated $700 million worth of tobacco seeds to poor countries with the promise they will buy back the leaves (Berlinguer, 1999). In Berlinguer's view, the World Health Organization has lost its political leadership in world health policy issues. The real health leaders have become the World Bank and the International Monetary Fund (1999). Dr. E. Goon of the World Health Organization (WHO) explains that health is a fundamental human right and the objective of the WHO is to ensure that everyone attains a level of health, which allows him or her to lead socially productive lives. The resources that are available, he feels should be available to every citizen (cited in Little, 1992). The AIDS pandemic seems far from this ideal. Globalization today means accumulation of money and power, an extraction of capital, which knows no boundaries. Human lives are being transformed into commodities and people are being ruled by a monetary fundamentalism creating a tragedy for humanity and a world with further inequalities (Berlinguer, 1999).

Weaving my text: We are together

My understanding of power is broadened by the words of J. Poling (1991), who says that power is relational. It encompasses the ability to both produce and experience an effect and is necessary to sustain a relationship. In its ideal form power is synonymous with life. The amount of power we each have is determined in relation to others. Healthy relationships are those in which self and other are continually transformed. As each participates in the experiences of the other, the relationship is enlarged and the subjective reality of each individual is enriched.

Power through relation rings true for me, it resonates within me because of what I experienced with the nurses on International Women's day, which occurred while I was in Ghana. Our sharing of life as women through story telling empowered us. I have always connected the term power with activities, which place one apart from the other, that separate winners and losers.

Gadow (1999) explains that through engagement people are able to co-author an interpretation better than either one on their own. In this engaged space, diversity and difference are encouraged and accommodated. We are required to make an effort to discover how the other views herself and the world; to try to understand what it is like to live her life from her point of view. It is a matter of relationship (C.Gilligan, cited in R.Dillon, 1992). Barbara Scott (cited in C.A. Taylor, 1993) speaks of objectification occurring when dominance theorizes about the other, thus positioning the other. We must become aware of how we position others. We must revise our own sense of positioning rather than how we theoretically respect or culturally see them. When we are in relation, it makes it more difficult to position the other as different from ourselves. On International Women's Day, we were just together; we didn't position one from the other.

Tangwa (1996) compares Western culture with African culture to help the reader understand the impact of difference in intercultural relations. He states," by virtue of its technological advancement, Western culture considers itself to be an oracle on all spheres and matters. The doctrine of 'might is right' and 'knowledge is power' leads to the pervasive desire to control, commercialize and monopolize everything." (p.185). While Western culture has greatly influenced other cultures, in particular African culture, it has been immune to philosophies and systems of thought from other cultures. Has this

immunity enhanced our sense of dominance, blocking potential for engagement and encouragement of diversity and difference? As Tangwa (2000) says, it would be ideal to combine the two cultures with Western culture empowering African culture and African culture humanizing Western culture. Might this ideal thought encourage the joint interpretation, which Gadow speaks of?

Canada: Who's world?

My professional involvement with a cultural brokering service organization in my city affords me many intercultural opportunities. Opportunities exist to learn about other cultures, to learn about my own culture and to learn about the effects each has on the other.

We sit, waiting in this familiar, yet foreign world. I sit here with Hope at her request, to provide support and familiarity in a world, which is so foreign to her. I am here to support Hope, a multicultural broker, so she can support her own people – refugees to Canada. I sit patiently, attempting to absorb this place, these surroundings. Hope quietly watches everything around her, leans towards me and with a vulnerable tone says, " I am afraid here. These people do not look okay to me, I do not feel safe here."

How do I explain my culture to her, one I am embedded in and know theoretically, but lack experience in many facets of it, to this woman who looks to me for safety and support. I realize at that moment that we are both feeling vulnerable as I experience feeling like a foreigner in this context. We have come to this service organization seeking supplies for a young Sudanese refugee mother who has neither

diapers nor formula for her infant. This organization has served many individuals who are homeless or in need. I have been asked to help this woman navigate my culture, but sometimes I don't feel at home in my own culture.

Hope asks me several information gathering questions in a row during our time at the center, such as "why are these people not working at something" and " will they hurt me?" I realize I cannot answer these questions about my world, but understand that this is all right.

What we share is a sense of vulnerability. We learn about each other as Hope tries to help her people in my world, and in attempting to understand each other's culture realize that all we have is dialogue, the opportunity to learn through communication with each other.

Seeking understanding: Who is the Other?

Julia Kristeva (cited in Olthius, 2000) states, "one sets her face against strangers because they remind us of that which is strange in us. This creates discomfort and triggers defensive reactions to difference and diversity in interpersonal relationships" (p. 4). I understand this otherness from Kristeva's quote, because I continue to feel the strangeness in myself when I think of my experiences in Ghana and what they evoked in me. Kristeva goes on to say that it is these defensive reactions, which interfere with our ability to truly see and honor the other as other. We are all raised in certain cultures and with repeated exposure to customs and values related to that culture, we assimilate them into our daily lives. Recognizing that cultural differences exist is not the same as respecting and understanding those differences (Erlin,1998). Inside myself I feel like the

other with intensity not experienced before. But while I seemed the other in situations in Africa, within myself I knew we were all the same humanity and my ability to connect with them was real. Was it a matter of honoring the other in myself and in the Africans whether here or there?

Browne (1993) provides us with a conceptual definition of respect. As a basic human right and moral principle, respect incorporates the values of human dignity, worthiness, uniqueness of persons and self-determination. Respect, she says, has many operational definitions, that vary across different social and cultural contexts. While this definition tells us in a theoretical way what respect is about; I cannot relate it very well to my intercultural experiences. It seems not to include the emaciated bodies I saw with my own healthy body in the same room or give direction to the difficulties when in the midst of situations I have described in Ghana. How is respect born, come to be present in the dialogue, to be integral to a lived moment?

If a person is willing to become someone who can temporarily transcend his or her own culture, beliefs and frameworks in order to understand another person of another culture, than dialogue can at least start on an equal plane and proceed as mutual sharing and reciprocal transaction (Karaban, 1991). In each of us resides the temptation to strive for control over difference rather than to connect with difference (Olthius, 2000). It is through dialogue that we recognize difference and difference begins to hold no threat.

I have always resisted the concepts of privilege and dominance. Born in a highly industrialized, economically dominant nation, into an affluent, educated family brought privilege and opportunity. My resistance to dominance is fueled by the risk of the "other"

being diminished, decreasing the possibility for the development of respect. Or does it diminish that possibility?

While I have always had sensitivity to other cultures and a calling to work with them, following my experience in Ghana, I know that being in relation with individuals from other cultures is extremely difficult and tenuous. Is it possible to truly enter another culture? I am not satisfied to answer this question from a place of comfort and safety. I want to learn how not to position others from my own dominant place as Taylor (1993) admonishes us, how can we find and open a space, and if this is possible create a place that helps us reach a greater potential in intercultural relations? As Keziah and I as well as Hope and I converse, how will our origins and our pasts that have brought us to this time show themselves?

Together in the Space

Henson's (1997) understanding of mutuality helps me fill the void of this question stated above. It is a feeling of connection and understanding, a dynamic exchange between people with a shared purpose. Power differentials are overcome. In Ghana Keziah and I exist in this mutual space we created together, where shared humanity seems to make otherness fall away. As in Canada, with Hope, this space of shared humanity presents itself with seemingly endless potential for relation is created. It is indeed a space, but more is required. Is it that windows of respect and many doors of approach must be integral to the space? Is it through mutual openness that the potential for connection emerges?

Olthius citing Levinas (2000) writes that since Auschwitz, we need a different ethic, an ethic that begins with responsibility rather than freedom, where the other has priority over self. But how does that live itself out in Ghana? What is the priority that the man's mournful eyes, his wasted body, his cultural practices have over me, a healthy white woman, and a nurse? It evokes compassion but is compassion one way only? It evokes helplessness and wanting to do something yet not knowing what to do and not having the tools at hand to do something? Is relation, being near, talking, enough? Is it all we have?

What does the other having priority over me mean in action, or does it mean action? I feel compassion for all in this situation and in order to feel compassion, say Ruiz and Minguez (2001), an intersubjective relationship involving recognition of the other and a sense of responsibility for his or her fate is necessary. This is facilitated, by seeing the face of the other, and listening to questions that come from beyond. But none of this is possible without a new moral culture, which sees the other as neighbor, not stranger.

Robin Dillon (1992) reminds us that we each have our own perspective from which we try to make sense of the world and ourselves. Respecting persons involves coming to understand them in light of their own self-conceptions and trying to see the world from their point of view. In relation we must account for our connectedness, our distinctness and our interdependence. Here with this man I begin to understand what sheer connectedness means; it calls for much from myself and from our larger world, not to just acknowledge it, and to live it out with him, it calls for more, but what?

Inherent knowledge, says Bergum (1994) is knowledge that comes through a person's "lived wholeness experienced from within rather than surveyed from without" (p.73). It is knowledge constructed through a unique individual experiencing her world and it can only be achieved through collaboration. We must move from a place of dominance where we think we can just apply knowledge to another person to a relational space where we understand what this means to the individual and we move forward to make a plan (Bergum, 1994). It is this level of inherent knowledge that I seek as I look into the man's eyes and he looks into mine. I realize the enormity of how much I need to understand about his living I and my living I and how we might together address his situation in the relational space (Bergum, 1994).

The Way Forward and Research Questions

Based on the above experiences and literature, I see clearly that the complexity of situations and factors related to intercultural work and dialogue are immense. However, I still feel caught by the need to understand more, though I see and acknowledge that a study of intercultural dialogue is likely to be an imprecise and perhaps a tenuous area of study. I realize more clearly now, that what is integral to the dialogue cannot be known a priori. We cannot employ a prior structure upon the dialogue. We cannot approach it with a prior thesis or in a prescriptive manner. I know that intercultural dialogue cannot be made into an objective thing, something to put on a shelf to be applied to all cultures. Yet I feel a need to directly engage in a conversation to understand more of intercultural dialogue's dynamics.

What I propose to do is to approach intercultural dialogue through conversations with a nurse, Keziah working in Ghana and myself, as well as a Multicultural Health Broker, Hope and myself and to look at related literature. Returning to the Ghanaian polyclinic I visited three years ago, I will observe the HIV counselor in her clinic duties with clients, as well as converse with her about the topics arising from the day's work. Upon my return to Canada, I will converse with Hope about the themes, which emerged in the initial conversations. My hope is that through conversation we can actively participate in an intercultural dialogue as well as arrive at some shared understanding of the nature of intercultural dialogue. While it is difficult to know how to structure research questions for a study of intercultural dialogue before engaging in a conversation, the following questions will guide the study.

Overall Research Question for the Study

What is the nature of intercultural dialogue?

Related Research Questions

What do conversations about HIV/AIDs between a Canadian and Ghanaian nurse show us about intercultural dialogue?

What factors influence the flow of intercultural dialogue?

What is the role of those influencing factors in intercultural dialogue?

What is needed in order to attain a deep learning and sharing by both parties?

How does dialogue influence our understanding?

CHAPTER 2: THE PATH OF THE STUDY

This chapter is divided into three parts. In Part One 1 will review relevant nursing literature to see how it informs my study. In Part One, my quest is to understand and question nursing literature. In Part Two, I will summarize my second visit to Ghana. In Part Three, I will outline the methodology for the study.

Part 1 - Nursing Literature

In the nursing literature, the terms transcultural, cross cultural, multicultural, and occasionally international nursing, seem to be used interchangeably when speaking about caring for clients from another culture. Nurses can access the Journal of Transcultural Nursing, dedicated to transcultural nursing issues, join a Transcultural Nursing Society and nursing care of clients from other cultures is now considered a specialty area within the discipline. Morse (1988) said, cultural variation was not considered to be significant in the provision of health care until the 1950's. The Western system with its package of beliefs, values, norms and practices was being provided to all people. Hagey (cited in Morse, 1988) stated that Florence Nightingale was indeed the first transcultural nurse, working in Crimea and Australia, but the concept of culture was limited to physiological differences between people. She comments that nursing remains entrenched in the notion of prescriptive cultural assessment tools and their uses.

Today, there is a mandate handed down from governments and nursing legislative bodies for nurses to provide culturally competent care. Operationalizing this mandate, however, is far from an easy task (cited in Douglas, 2002). Several nursing leaders beginning with Leininger more than 40 years ago have attempted to conquer this task.

Leininger (1978) defines transcultural nursing as a sub-field of nursing which focuses on the comparative study of cultures with the goal of identifying differences and similarities in the dominant beliefs, values and practices of designated groups of people. Leininger opened the field for nursing and stressed the importance of understanding transcultural nursing. More recently, prescriptive models and frameworks designed to organize our cultural knowledge and apply it to health care delivery, have been formulated by Giger, Davidhizar, Campinha-Bacote, and Purnell (Douglas, 2002). One has to question whether nursing's focus on the development of a professional body of knowledge has sometimes objectified nursing work, including intercultural work? Due to the prescriptive nature of transcultural models and frameworks, has nursing inadvertently objectified people of other cultures, by grouping and labeling them? Is the assumption that all East Indian clients hold the same beliefs, values and practices related to healthcare? We know that differences between people within a culture can be as diverse as people of different cultures, with each member embracing differing numbers of traditions and practices of their culture (Dreher & MacNaughton, 2002). The uniqueness of the individual is surely lost when they are labeled according to their culture.

In reviewing the available nursing models, there is little mention of dialogue as a method to learn about one's culture, or perhaps it is taken for granted or swallowed up in the nursing history tool or format, relegated to demographics alone. Engaging in dialogue requires relation with another; discovering and learning can be mutual and equal. The focus in nursing models seems to be learning "about" another culture as opposed to learning "with" another culture. According to Leininger (cited in Dreher & MacNaughton, 2002) nurses must have in-depth awareness of many different cultures in

order to provide culturally specific care. This focus has led me to feel discomfort at the possibility of objectification, as well as to question and try to understand the differences between the prefixes commonly used by nursing related to cultural work.

Webster's Ninth Collegiate Dictionary (1984) defines the prefix "trans", as "across, beyond". The prefix "cross" is defined as, "to be situated across", and the prefix "multi" is defined as "many, more than one or two". The less commonly used prefix, "inter" is defined using such words as, "between, among, in the midst, reciprocal, and shared by". And so I am drawn to the term intercultural, indicating potential for relation, dialogue, and shared learning, while reducing the risk of objectification of the other.

As I question this objectification of the other and given my story in Chapter One, I notice that nursing literature primarily dealing with the concepts of respect and power relations related to cultural competence is not abundant. Every nurse needs to relate in a respectful way to their clients, whether or not they are from another culture. Do we actually need a specialty area for cultural competence when it is an every day occurrence in nursing? Every nurse in practice will encounter and care for clients from diverse cultural backgrounds. In naming this specialty area of nursing which deals with expertise in cultural competence, does it serve to objectify cultural work rather than having it embedded in nursing practice itself? Agreeably, the profession does and should advance knowledge and I question if this area of literature does this in a respectful way?

There should no argument about the quest for cultural competence being necessary, as North American societies become increasingly multi-ethnic and culturally diverse. Dreher & MacNaughton (2002) say, " a standard of cultural competency in all

human services is wholesome, desirable and consistent with democratic principles" (p.181). They say that cultural competence must begin by us acknowledging the fundamental ethnocentric attitude of Western healthcare. In a review of the most commonly used cultural care models, I found only one that actively talks about the nurse examining her own culture before learning about another. The first construct in Campinha-Bacote's (2002) model of cultural competence, is cultural awareness, primarily a self-examination and in-depth exploration of one's own cultural background. It is only with this starting point of humility and willingness for self-transformation that shared learning can happen between cultures. While the creation and use of models and frameworks in nursing is important, we must be aware of the potential for objectification of our clients with their use. Does our cultural literature in nursing still contain the hegemony of the Western model in it, as it lacks attention to the ethical stances of respect and power? Does it serve to objectify the other?

With these questions in mind, I sought further literature and found Meleis'& Im's (1999) work on marginalization. They remind us that as nurses, we have asserted that nursing is about dialogue, and in-depth interactions. Through interactions and dialogue we influence each other's world. Without more knowledge about how dialogue enhances understanding, we are less tolerant of what we do not understand, become less familiar with diversity and difference, and settle into a more dehumanizing environment. In regard to learning about other cultures, gathering knowledge without attention to structural, political, economic and positional constraints itself is dehumanizing. Cultures cannot be examined or understood outside their politics and history, including the power structures within and outside of them (Meleis, 1996).

Here I begin to gain, through Meleis' work, not only more insight into otherness and culture, but also see that dialogue, just as I propose to engage in with a Ghanaian nurse, is essential in finding the way. At times I feel part of a dehumanizing culture. Is my real quest to extract myself from this dehumanizing way, to find, experience and declare another way or mostly is it to learn how to enter another culture and also be at home in my own? In his work on dialogue in a postcolonial world, Homi Bhabha (1994) writes that the third space, the space located between the two worldviews is the only place where cultures can meet and dialogue. Barrera and Corso (2002) also use the term third space in their work on cultural competence in education, and define it as " the creative construction of interactional space that integrates complimentary aspects of contradictions" (p. 108)

Meleis (1996), and her work on culturally competent scholarship also inform me. She presents eight criteria to be used by researchers in order to ensure cultural competence in the development of knowledge. *Contextuality* involves sensitivity to all the conditions that contribute to participant's responses and to the interpretation of situations informed by the participant's experiences (Meleis, 1996). *Relevance* refers to the extent to which the research questions are considered meaningful and significant to the population being studied, as seen from their perspective. Relating to *communication styles,* for research to be culturally competent it must include evidence of understanding the variations in language, symbols and communication styles of the population being studied (Meleis, 1996). The researcher must be aware of and acknowledge *power differentials.* An attempt should be made to establish more horizontal relationships and shared ownership of data (Meleis, 1996). The goal of any culturally competent researcher

is to uncover the experiences of the participants in ways that are authentic to them and understandable to the audience. This represents the criteria of *disclosure* (Meleis, 1996). *Reciprocation* is achieved when the goals of both the researcher and the participants are identified and attempts are made to address these goals. *Empowerment* refers to the consciousness-raising of the researcher and the participants through the research process. Finally, *time* must be used in a flexible manner, to develop a trusting relationship, and to demonstrate respect for the potential differences in the cultural meaning of time (Meleis, 1996).

In the discipline of nursing we are often educated to know ahead how to deal with many practice situations. Through the application of a known nursing model of practice or an assessment tool, the nurse provides competent care. While this is realistic and helpful in many nursing situations, it is difficult to follow this pattern in intercultural work. Much of the nursing literature related to cultural work fits comfortably into dominant western thought processes, which I have found serves to stifle interaction and potential understanding when working with another culture.

Part 2 – Ghana: The second visit

Amidst doubting questions from others at home regarding my need to return to this place, I arrived back in Ghana. Questions about my need to return to a place which is not easy and sometimes uncomfortable surrounded me, maybe driven by others' fears and concerns for my health. Upon my return, I was immediately reminded of the extremes experienced in this environment, the heat, humidity, the poverty, and the difficult daily existence. Still, I felt in some way settled and relieved to be back. I was keen to

experience a return visit, to understand my call to this place. Within the first hours I found words, which helped me understand my experience of three years ago. I experience life in Ghana through my body, while in Canada I experience life primarily in a cognitive, intellectual manner. To be in Ghana is to feel life in your body. The heat, humidity, food, illness, spirituality, sexuality are all expressed through the body.

My first visit to the department of nursing brought familiar interactions and good feelings. I was remembered, as I also remembered the people there. Through generous greetings, some appeared intrigued and surprised by my interest in returning to Ghana. They seemed to see my return to Ghana as demonstrated sincerity about my interest in cultural work and my interest in them as people.

Over the next days, we talked about my last visit and they seemed surprised that I remembered so many details about them, asking about their children, their grandchildren and their lives. I was genuinely interested and they saw this. I reached out through conversation and they seemed touched by the fact that I remembered so much about them.

The department drivers were directed to drive me to the Noguchi Institute to check on my ethics process. They accepted their instructions, obediently. I approached them, happy to see them again. They were an integral part of my experience from three years ago. I called them by name and reintroduced myself. Their faces lit up, with full animation at the surprise of being remembered and acknowledged at this time. They immediately verbalized their shock at being remembered. We shared stories from my original trip, laughed and I was left wondering what it was that facilitated this interaction.

Was it caring, was it willingness to engage, showing respect for another human being's existence, someone who immensely helped me by driving me to the ethics meeting? This shock of someone remembering them and some details of their life seemed very meaningful to them.

At the Noguchi Institute I was informed that my ethics process was not yet completed, but I was welcome to meet with the registrar. My return to Ghana was a chance to live my thesis work, engage in intercultural dialogue, and I learned that being present with face to face interaction was critical to this process. It reinforced for me the importance of actually being present in my body, in Ghana, as I engaged in the ethics process. The ensuing dialogue with the Registrar of the Institute, created shared understanding about my intentions with my research. It also provided an opportunity for the Registrar to have a face to relate to the paper application.

Three years ago, Keziah and I learned about each other through shared daily conversations. We were nurses together and her world was and still remains full of desperate health needs. We seemed to share the yet unspoken possibilities for relation we saw in each other and with Keziah, I felt an endless potential for learning. My experience of talking with Keziah at that time, led me to want what Smith (1994) refers to as a language of understanding where difference presents an opportunity to consider the limitations of one's own understanding. Gadamer (cited in Smith, 1994) speaks of each of us bringing our forestructure or horizon of understanding into interactions with others. These forestructures or prejudices (Gadamer, 1989) enable us to engage in dialogue as we share these with each other. Indeed they are essential in conversation. Our horizons meet, move and become fused, and change through dialogical engagement with the opportunity

for new understanding emerging. How does one begin to have dialogue with a text of this enormity? Yet here I was again in Ghana ready to start. My position of privilege arrived with me, stayed with me and I had to find the way. Some might say that my expedited ethics was because I was in a position of privilege, others might say being there in the body showed my interest and commitment.

Keziah and I greeted each other with excitement, and hope. Our sparse communication over the last three years had not set us apart and we picked up where we had left off. We spoke about the upcoming data collection and she was worried she would not know enough to be of help, do a good enough job. I assured her that we would both be discovering as we proceeded; the process of conversation would hopefully guide us. The only thing we needed was to be committed to being in dialogue. There was no other known at this point.

At the clinic I observed primarily HIV patients, coming with questions, ill health or waiting for a diagnostic test result. The first three clients were young girls. They had left school during secondary education because their families could not afford for them to be there. They needed to be working, supporting themselves. They were all in relationships with men who supported them financially and this was how they survived, economically. These men may have had other girlfriends, they were unsure, but due to financial need, they all felt they had limited options. They needed a place to stay and food to eat. I realize, after spending time in the clinic that the context of each client's story is very common. So our conversations at the end of the day centered on broader topics such as gender, education, HIV, and the church. We ended each clinic day with questions or concerns from the day, and together Keziah and I decided what to converse about on the

audiotape. Quickly we gained confidence in letting a conversation progress without a set agenda and the research agenda faded as we started talking.

Part 3: Methodology

" If I give you my truth but do not receive your truth in return there can be no truth between us" (Thomas Merton cited in Smith, 1994, p.120).

Hermeneutic Inquiry

The conversational nature of hermeneutic truth requires that the researcher report her own transformations arrived at through the process of inquiry. Commitment to staying with each other through conversation is necessary in order to build a common shared reality in a "spirit of self-forgetfulness", a finding of oneself in relation to others (Smith, 1994). Jardine (1992) says that dialogue and conversation figure prominently in interpretive work because emerging understanding is neither yours, nor mine but ours together. Understanding the meaning of another's reality and experience is particularly important in matters of health and illness.

I am drawn to the tenets of hermeneutics as a way to explore intercultural dialogue as it calls us to understand something from all sides. Knowledge is not acquired and applied, but shared understanding emerges through the commitment of staying with one another in the process. Gadamer (1989), writes that the answer to any question is not found in expertise, but in dialogue, where the other half of the understanding is found.

Hermeneutics is an ancient discipline suggesting the idea of bringing something to understanding, particularly where this process involves language (Leonard, 1994).

Based on the Greek character Hermes, the youthful messenger delivering messages between the Gods and the mortals on earth, hermeneutics engages in the mediation of meaning through the practice of interpretation (Smith, 1994). Heidegger (cited in Robertson-Malt, 1999) says that unlike the traditional notion of experience and knowledge being separate, static and non-relational, hermeneutics is synonymous with the way in which we interpret our everyday "being in the world", the relational basis of our daily lives and understanding of the world. The success of hermeneutics lies in it's ability to gain greater understanding of an experience while maintaining the context of the everyday lived experience where meaning resides (Robertson-Malt, 1999).

Phenomenological and hermeneutic research explores the humanness of being in the world. It strives to interpret and understand rather than to observe and explain. Where phenomenology is the description of an experience, hermeneutics is the interpretation of the experience (Van Manen, 1997). With questions that search for understanding, there can be no separation of the knowledge of the experience from the meaning of the experience (Bergum, 1989). The success of hermeneutics as an interpretive methodology is in its ability to gain greater understanding of an experience while maintaining the context of the lived experience where meaning lives (Robertson-Malt, 1999). Van der Zalm and Bergum (2000) speak of the knowledge resulting from hermeneutic inquiry being very useful to nursing. This knowledge reforms understanding, leading us to more thoughtful action with others. The more that is known about human experience the more sensitivity can exist in relation to patients, families and other nurses. However, the nurse must be a participant, sharing in the patient's journey (Bergum, 1994).

Hermeneutic work is guided by four assumptions (Leonard, 1994). First, we always approach our interpretation with pre-understanding or a fore-structure of understanding. Second, we approach the research question through an interpretive lens that orients us to the phenomena, allowing a preliminary sense of what constitutes a question and the answer. (Gadamer, cited in Bergum, 1989) says that questioning indicates the presence of an unsettled issue. It invites a reply, a dialogue, a searching out of similarities and differences. Gadamer (1989) says, " the essence of a question is to open up possibilities and keep them open" (p. 299). Third, the interpretive process is always circular, moving back and forth between part and whole and between initial fore-structure and what is being revealed. Fourth, there is no point from which we have a privileged or foundational view of the world that is ahistorical, atemporal and apolitical (Leonard, 1994).

Based on these assumptions, Smith (1994) shares the requirements necessary for hermeneutic work. First, we must develop a deep attentiveness to language, our own and others, how it is used, its meaning. Understanding between persons is only possible through conversation. Gadamer (cited in Smith, 1994) says that language contains in it the anticipation of being transformed in the face of new realities. Our transformation is determined by our orientation to, and attitude towards what meets us as new. Secondly, we must deepen our sense of the basic interpretability of life. We interpret life according to our macro-frames. Good interpretation is a creative act of developing identity within differences and giving voice to the aspects of our lives usually suppressed under the weight of the dominant economic and political fundamentals of the time and place. Good interpretation shows the connection between experience and expression (Smith, 1994).

According to David Jardine (1992) interpretation is the generating of meaning that comes with the eruption of new in the midst of the already familiar. It is not possible without a living connection to the topic. Third is that we are interested in overall human meaning and how we make sense of our lives. The final requirement is that hermeneutics creates meaning. I must be subjectively involved, and together in conversation with another, we deepen our collective understanding of the world (Smith, 1994). Understanding, interpretation, and meaningfulness are grounded hermeneutically in a sense of the dialogical, intersubjective, and conversational nature of human experience (Smith, 1994).

I am also informed and guided by Smith (1994) who says that hermeneutics is helpful in mediating meaning in the context of cultural differences. Hermeneutics shows us the way the meaning of anything is arrived at referentially and relationally. Coming to understand something requires a commitment to a process of emerging understanding as well as the occurrence of perpetual self-transformation. In conversation, the same occurs with the other, and together trust is developed to gain understanding of one another. "We try to find a language of understanding that sees difference as an invitation to consider the boundaries and limits of one's own understanding. Identity means nothing without a set of relations. The story of our shared future is contained in the other" (Smith, 2003). Gadamer (cited in Smith, 2003) tells us that identity is only something "we are" not "I am". Engagement with new realities creates the potential for development of new shared realities.

Bergum (1992) speaks of the relational space. It is a space where relation "moves and changes like dance partners sensitive to the movement and rhythm of the other" (p.82). Keziah and I would never leave this space without mutual consent, our

commitment growing through each meeting. Through conversations about differences, emerged greater understanding and sometimes an awareness of similarities in ways of thinking. A resulting decrease in our sense of vulnerability opened the way. Around us the space became occupied with trust, respect, excitement and above all, hope. Was it the hope of shared understanding? Gadamer (cited in Smith, 1994) says we start with our prejudices or fore-structures of understanding and through a "fusion of horizons" engaged in dialogically, shared understanding emerges (p. 110).

Bergum (1989) states that questions that search for understanding, knowledge and meaning of the experience cannot be separate. "It is from a position of shared history that understanding comes into being" (p. 49). Bollnow (cited in Bergum, 1989) says that, " the community and universality of truth means that we engage with others, in full reciprocal openness, and that in such a testing and clarifying dialogue we stand on the common ground of rational discussion" (p.52). The space became our shared place of learning, discovering and growing with our similarities and differences. We were both being transformed.

In the intercultural dialogue literature from education, as stated above, Barrera and Corso (2002) refer to this space as a third space. We must learn to open this space, become comfortable dwelling in the space, and allow shared understanding to emerge. Dialogue itself can become objectified, so even with sensitive understanding of intercultural dialogue we must put ourselves into and dwell in the third space, a space of unknown. In conversation, Smith reminds us that one's knowledge and expertise is never enough to create understanding, because in dialogue, individuals engage in a conversation that includes their experiences. The use of hermeneutic methodology shows

us that we have to gain understanding through conversation, and that the emerging understanding belongs to both participants together.

Ethical considerations

Following ethics approval from the University of Alberta Health Ethics Review Board, Panel B, I travelled to Ghana to seek ethics approval from the University of Ghana Health Sciences Ethics Review Board. That approval was obtained and I began gathering data through conversations with Keziah as well as through field notes and keeping a research and a personal journal. The study included two participants I dialogue with; one in Ghana named Keziah and one in Canada named Hope. Their names have been altered to protect their identity. The Ghanaian setting for the study was a public health polyclinic whose name has also been altered to protect identities. The Canadian setting for the study was a cultural brokering organization.

Method and Data Collection

During my visit to Ghana, I observed Keziah as she carried out her clinic activities, wrote field notes and at the end of the day, had audio-taped conversations with her, guided by questions which arose from the workday. Following each clinic day, we discussed the events of the day and, inevitably, questions arose, with each of us wanting further information or clarification. Those questions led us into our conversations. As stated above, together we set the agenda for the conversation, often coming to the theme of the conversation later in the dialogue.

Due to the fact that transcription of the conversations was to occur in Canada, following the taping of each conversation, together we listened to the playback. This was to ensure clarity and to begin identifying emerging themes from the conversations. Following the collection of data through seven conversations with Keziah, each one, one and one-half hours in length, I returned to Edmonton. I contacted the Multicultural Health Brokers' Cooperative and held three audio-taped conversations with a health broker around the research questions and the preliminary themes, which had emerged from the conversations held in Ghana.

During my first visit to the clinic three years ago, and my conversations with Keziah, I had a glimpse of the potential for intercultural work, only beginning to grasp its magnitude. My great amount of learning then, came through the individual situations I found myself situated in, followed by conversations with Keziah which increased both our levels of understanding. This experience called me back to Ghana and towards further understanding through connection to the clinic and Keziah. David Jardine (1992) guides my understanding on the particularity of learning through an individual instance. The particularity of clinic work with Keziah opened a door to potential understanding that could not be opened otherwise. Understanding from politics and literature was not sufficient for me. Situating myself inside the clinic experiences, interacting with the faces and the bodies in their suffering, my own body suffering in high temperatures was a necessary occurrence and helped me understand and integrate the literature in the situations I was in. While the situations in the clinic shared commonalities, each one also was unique in some way. Jardine says, " the instance is irreplaceable in its particularity, because that very particularity can have a generative, transformative effect that cannot be

duplicated" (p. 56). While Jardine speaks of a specific instance that addresses us and triggers an inquiry, like Ghana spoke to me three years ago , his notion of the individual case informs my study and reverberates within me. He writes of the initiation of a new teacher and says, " initiation has to do with renewal, and with generative transformations in how we understand ourselves" (p.61). I find myself identifying with his words as I seek understanding of myself in an intercultural context and long for a renewal of my faith in a just global society.

Data analysis

Keziah, Hope and I attempted to preserve the uniqueness of each participant's lived experience while gaining an understanding of the experience under investigation (Streubert & Carpenter, 1999). Analysis began during the conversations, as we actively listened to and thought about the meaning of what was being said. Following each taped conversation we listened to the recording, as stated above, in order to direct our understanding, identify areas to probe more deeply in conversation, and develop our questions for the next dialogue, as at times, our questions guided the next conversation, at other times, thoughts and feelings arising from the clinic day guided us and occasionally, the stories from my first visit stimulated topics for conversation.

After listening to the audiotaped conversations together, we identified preliminary themes emerging from each conversation. Verbatim transcriptions were prepared after returning to Canada. The transcript was read in its entirety first. The next step involved line by line reading, noting words, phrases, and meanings that were particularly revealing and stood out in terms of the research questions. Each transcript was read on its own as

well as the related field notes. All of the significant phrases were underlined and labeled in the margin. Writing and rewriting occurred as the researcher moved from theme identification and comparison to a picture of the whole experience (Bergum, 1989). Field notes as well as my research journal were used to clarify the themes from the conversation data.

Reliability and Validity

In order to address reliability and validity issues, as they apply to my study, I returned to Meleis's (1996) criteria for culturally competent scholarship discussed in chapter one. Her eight criteria assist researchers in ensuring cultural competence in the development of knowledge. I attempted at all times to be aware of and sensitive to the conditions that contributed to Keziah's and Hope's responses and to the interpretation of these responses. As we conversed, I attempted to confirm what I had heard and understood, having respect for the *contextuality* of the situation. *Relevance* of the research questions was ensured by my sharing them with the Ghanaian Health Sciences Ethics review board, as well as with Keziah and Hope prior to beginning data collection. *Communication styles* in intercultural work must be acknowledged, understood and respected. Our conversations were conducted in English, but Keziah, Hope and I attempted to clarify any potential misunderstanding regarding the meaning of language as we progressed through our conversations. In order to acknowledge and manage *power differentials* between us, we spoke of all the various levels of power potentially involved in our relationships. I am North American; Keziah and Hope are African. Throughout the data collection period, I was in Keziah's world, but as we discussed, her world is very much influenced by the domination of North America. In Canada, Hope was in my

world. We spoke openly about power differentials, acknowledging that we were all products of systems much larger than we were.

Being sensitive to the criteria of *disclosure;* the uncovering of the participant's experiences in a way which is authentic to them, we reviewed our taped conversations, together. It was important that Keziah and Hope were represented, authentically, as they wanted to be, and that they felt safe with that representation. As well, Keziah and Hope reviewed all finalized themes and their presentation, before the writing was finalized. *Reciprocation* is achieved when the goals of both the researcher and the participant are identified and addressed. We openly discussed our goals and in Ghana decided on the nature of each conversation together following the workday at the clinic. *Empowerment* of both the researcher and participants is essential for cultural competence in research and Keziah, Hope and I all felt as though our consciousness and awareness of each other was raised through our conversations and time spent together. I attempted to approach the cultural criteria of *time* in a flexible and respectful manner. With limited time for data collection and the pressures of completing my research, I found this challenging. The meaning of time is very different between our cultures, as I had experienced on my previous visit and through my work in Edmonton. We discussed each of our expectations around time before beginning any research conversations. Our relationship which was based on high levels of respect and caring continued to develop through this process, and we were able to manage the difference in time expectations with humor, patience, and open communication. For example, when I moved too fast or too far ahead of Keziah with my expectations, she gently brought me back to the present moment, with a comment such as, "we will decide what is next when we get to next". Similarly, showing

respect for my time line, we engaged in further research conversations often when she could have chosen to rest or relax.

CHAPTER 3: THE DIALOGUE

> " There is an endless set of threads throughout the universe. At every crossing of the threads there is an individual. And every individual is a crystal bead. And every crystal bead reflects not only the light from every other crystal in the net but also every other reflection throughout the entire universe" (Indra's net, from the Rig Veda, as described by A. Adams, in M. Wheatley, 2002),

In this chapter, I present the themes of the study that emerged from the dialogues with the research participants, Keziah and Hope. The themes are presented in the following order: The Embodied Experience of Life, Money makes the world go around, Cultural Strength, and Education: Investing in the future. Throughout the discussion of the themes, I insert on-going excerpts from the dialogues as well as my own reflections as a way to continue my own dialogue with the emerging text and to situate the reader in the findings of the study.

Throughout the chapter, quotes taken from literature and my journal are indented, while excerpts from conversational transcripts are written in italics. The majority of conversations occurred in Ghana with Keziah. Following my return to Canada, I held several more conversations with Hope, to gather her perspective on the preliminary themes and the nature of intercultural dialogue.

Theme 1: The embodied experience of life

Here I am in Ghana again, experiencing life in and out of the clinic. I write the following thoughts in my personal journal.

"I am pushed past my comfort zone. I am always hungry, the heat is stifling and my energy level is challenged. I feel nauseated and my heart pounds in my ears, chest and hands. I feel unclean as the red earth clings to my perspiration. I help carry heavy pails of water in order to clean ourselves. I learn to appreciate simple pleasures in life."

The body roots you in the present

Julie: "I feel everything in my body here; the heat, hunger, loneliness, fear. I even notice that spirituality is experienced through the body. At church I see people whose hearts are so full that their bodies cannot be still. As the service progresses, their bodies moves increasingly into dancing, and jumping."

Keziah: "It's like we let ourselves go, especially in church. Our cultural traditions are very passionate. We know how to enjoy ourselves, how to celebrate."

The experience of being in Ghana was one of constantly feeling life in one's body and therefore, very much rooted in the present moment. The heat, humidity, hunger, fatigue, and even spirituality are experienced through the body and fully felt in a sometimes painfully real way. Being rooted in the body opened the possibility for experiencing life's moments as very present and often with a sense of vulnerability. Here I had the opportunity to be fully attentive, present and engaged in the experience as well as experiencing others in the same way. I understand now that in my Western existence, I often live in my head, a cognitive existence, where I can be forgetful of the vulnerability I felt in Ghana through this enhanced sensation of bodily presence. Living fully in my body and feeling life, affected intercultural dialogue to the extent that I could not escape the vulnerability I felt. Everyday in the clinic, I saw Keziah choose this way, to be fully

present to her clients, never theorizing or hiding away behind expert knowledge. Her knowledge as a professional nurse gave her the authority for her to choose another way, a very prescriptive way of how to care for one's self with the HIV virus. Yet, her commitment to the experience of her patients and to the present moment did not allow her to apply theoretical knowledge alone. Rather she met the patients and listened to them.

Keziah: I have had a case where a couple came for premarital HIV testing. The gentleman asked if either of them tested positive, would it mean they could not be married? I told them the decision was entirely theirs as two consenting adults, however, if one was infected they would have to think about the possibility of the other person becoming infected and also think of children being born to them.

Julie: Did this couple really want to be tested or was this about pressure from the church leaders?

Keziah: Well, they returned the next day to say they would not test because the gentleman had spent a lot of money on the wedding and did not want to take a chance that the church would not marry them if one had a positive test result. I told them the church has no right to do that, but still they refused.

Julie: So essentially, something other than knowledge of the disease, concern for each other and their potential children was how they made their decision. You must find that frustrating.

Keziah: Yes, but there is not much I can do about that.

David Smith, in conversation with me reminded me that expert knowledge alone does not enable conversation. I came to Ghana with some amount of expert nursing knowledge and soon learned that it did not matter as much as living this experience. I knew my knowledge was there, but grew to understand that it would never be enough to understand the way of life here in Ghana. Staying rooted in the present demanded immediacy. It kept me from wandering to the past, into the future, and my energy and

concentration stayed with the present moment, with the situation directly in front of me. Keziah and I spoke of our experience and knowledge of different traditions.

Julie: When we talk about traditions, which we may experience in different ways in our home countries, like for instance, female genital mutilation, do you wonder what we think about it or what we think about how you think about it? Does that become important to you?

Keziah: Yes, sometimes it does, but we know generally, people in the Western world frown on the practice. Even here in Ghana, we know it is practiced in certain areas and some of us frown on it.

Julie: Okay, what if you were a nurse who thought it was just fine and we arrive with our pinions. Would there be a challenge to our communication?

Keziah: Well……

Julie: It is essentially about being careful of judgments. It is about respect, really.

Keziah: Yes, and by virtue of my training as a counselor, having had to address my self-awareness and values, I'm sure I would have understood if you felt that way.

Julie: I came to Ghana trying to soak up as much learning as I could, without judgment. Similar to how you might think about our culture being very individualistic. So, then, how do we communicate about that and have both of us okay, learning, listening, understanding and appreciating the other?

Keziah: I have realized that being judgmental doesn't help. You need to respect each other's cultural practices.

Julie: Yes, if I choose to be judgmental, I close the door to expanding my horizons of what I understand to be okay.

HIV/AIDS

The experience of participating and dialoguing about Keziah's daily work in the clinic opened a window for me to see elements of intercultural dialogue that I had not seen before. I saw her interact in many different intercultural contexts, which presented

themselves at the clinic. Differences based on tribal origin, language, country of origin, gender, cultural and religious contexts amongst Ghanaian people, were all approached with respect, openness and sensitivity. Through these challenging experiences, I concentrated on staying rooted in the present moment, in the dialogue, which would create understanding, and keep me from theorizing. Yet, I also realized that while I was rooted in the present moment in the clinic, I also had one foot rooted in the global issues surrounding the enormously tragic health issues I observed in the clinic. It was this understanding that helped me appreciate the very difficult task of being present in so many aspects of reality. We conversed often about HIV illness.

Julie: HIV is the same disease everywhere in the world, but it looks different in different places. Is that primarily due to available resources and cultural practices, do you think?

Keziah: In Ghana discrimination and stigmatization are huge problems because disease transmission is through sexual contact. Talking about sex is a taboo. It is thought that only bad people talk about sex. Unfortunately, due to many reasons, but certainly the stigma issue, we see most HIV positive individuals when they are very ill, when their bodies are frail and failing. They can no longer work and have no way to support themselves.

Julie: In our environment, we have HIV/AIDS patients who are treated and maintained for many years with anti-retroviral medications.

As I looked over the clinic record book for new HIV infections in the last few months, the stark reality was clear. Women with low levels of education, in low paying jobs were gravely over represented. HIV is considered a developmental condition, a social and economic condition, and I strived for understanding about the church's role in this development issue. Keziah explained the current understanding of some church leaders.

Keziah: So long as you are a Christian, it is thought that you won't get infected. One of my clients, a couple was not too upset by the gentleman's HIV diagnosis because they said they had a wonderful pastor who would pray for him, even without going to see him and he would be healed.

Julie: Is this about denial or is it related to lack of education about the disease?

Keziah: Probably both, but I think there is a real lack of education about the disease and lots of superstition. In the meantime, the woman tested and unfortunately she was positive. Her child was negative.

Similarly, another client said he had been prayed for by his pastor and was healed, so he would test again, and expected to have a negative result. Sadly, Keziah confirmed that he tested positive on all subsequent tests. Clearly, every sector must be involved in the fight against HIV/AIDs, and the church is no exception. Some of them ask their members to voluntarily test before being married, but provide little support to those whose results indicate presence of the HIV virus. Keziah believes that through education there is great hope for increased understanding, particularly through the delivery of the compassion and care message being given to church leaders and organizations.

Theme 2: Money makes the world go round

To help myself understand my world, Hope's world and Keziah's world and the space we inhabited together, I remembered the words of Tangwa (1996) "Might is right and knowledge is power" (p. 185). He charges the western world with talking more than it listens, and when occasionally condescending to hear others, it hears only what it wants to hear…essentially an echo of it's own voice". Keziah and I read Tangwa together.

Knowledge is Power

" By virtue of its' technological advancement, western culture is today the dominant culture in the world. The western world considers itself the infallible oracle on all spheres and matters. Because of this, western culture has developed a high degree of immunity and imperviousness against influences from other cultures, except in areas where exploitation can occur" (Tangwa, 1996).

This conversation followed the reading of Tangwa's quote:

Keziah: What he is saying is quite true. You know, before, the Africans had their own culture, a clear identity. Then it happened with the introduction of western culture and the television and so on that people wanted a change. Even our dress became western and fewer people wore our traditional cloths.

Julie: Is that a matter of wanting these things because they did not have them, or was there some sense of pressure to acquire these things from the west?

Keziah: It's a combination of all those factors. Families would travel out of Africa and bring back these things. Some of the things, like cell phones, make life more convenient, easier, but they are affecting our children growing up. It is affecting their education when they want to watch television.

Julie: It is difficult if people here feel pressure to keep up with the western world.

Keziah: There is some pressure and sense of competition, competition set up by the western world.

Ruiz and Minguez (2001) tell us that the poverty and exploitation of the developing world is a problem of human dignity. It is a moral problem involving those suffering poverty and dependency as well as those who cause it. The poor and

marginalized have no more interest or moral relevance for us than any other abstraction. They also say that it is compassion, which makes all humans equal. "More than reason, it is the innate repugnance at seeing another suffer that makes us fellow man" (p. 168). It is the experience of another's suffering which historically has prompted demands for the end of such situations. In regard to the globalization process, the say, "a new moral culture is required that sees the other as neighbour, not stranger" (p.171). It is only an active show of compassion, which will free politics of market logic and provide the basis for a society at peace.

In Berlinguer's (1999) passionate way, he challenges us about our willingness to remain knowingly and blindly in our comfort zones. He says, " it is hard to imagine people can feel isolated and protected, sitting smugly in the double cocoon of insensibility and unresponsiveness. The highly developed world seems to believe they can enjoy the best possible comforts separate from the suffering of the rest of the world" (p. 590). Keziah and I conversed about my experience of entering her world.

Keziah: Almost everything here has to be improvised in health care. Sometimes it is so difficult and many nurses are burned out.

Julie: I see there is a big difference between us here. We have access to immense numbers of resources in our health care system and we don't have to be very creative. We just pick up supplies and go to do the job. I find creativity is the norm here.

Keziah: Yes, it is. But it is interesting to note that nurses, students that come from Canada just flow into the system. They don't complain, they are excited and ready to do anything, ready to improvise like the others are doing, ready to learn more. It amazes me. They are hard working, they are very interested and some say they want to come back to Ghana.

Julie: Yes, I understand that. That is how I was. I wanted to learn more and more. For me the experience was a tremendously good thing.

For the last three years, since my first visit, I have seen the world in a much more global way. Now I experience the world as one place.

While discussing my call to Africa, my need to experience this place again, I told Keziah that people at home asked me why I would want to go to Africa, especially a second time. They say, " if life there is uncomfortable there, why would you put yourself through that?" I explained my need to learn through experience and I shared with Keziah my impatience with people who think they know, but have not learned through experience.

Through our interactions and through this related literature, I understood that intercultural dialogue becomes even more challenging with the interplay of knowledge, power and wealth, at a global level. We had a conversation following a television show about African countries and the International Monetary Fund (IMF).

Julie: Would you consider the involvement of the World Bank and the IMF to be good and bad?

Keziah: Yes, in Ghana, most of the arguments are that the World Bank and the IMF place conditions on loan money to Ghana. We must remove all subsidies from our products, but the western world is allowed to have subsidies in certain sectors. Why is this so? There used to be subsidies on petroleum products and a lot of them have been removed. We must now pay the actual price. When you look at our society, when at least 50% of the population is illiterate and they are not skillful and not educated.

Julie: Does their presence in Ghana do any good?

Keziah: Yes, sometimes African heads of government abuse power and do not use money to help the people. So the outside help keeps them in check. The negative again, is that sometimes there are so many controls and rules set on loan money that it affects the very people who they are trying to help

I wonder what the relationship between education, money and power is, and if knowledge is power, as Tangwa says, why does the developed world not recognize the developing world's knowledge, particularly about HIV/AIDS? I observed well-developed educational programs for HIV/AIDs in Ghana. They were comprehensive and multidisciplinary in nature. I wrote the following questions in my personal journal. Why does the rest of the world not value this knowledge? Is knowledge only considered valuable when it is related to economic issues? Why is so much attention given to economic growth issues within the literature? I was impressed by the magnitude and expertise of the HIV education programs in Ghana and wonder why the rest of the world knows little of these? Why do we, in the developed world only see statistics of the HIV/AIDS epidemic and not these primary care activities? Why is this knowledge not considered powerful?

Privilege, comfort and responsibility

Julie: Should the international community in your mind supply some of the resources you need to combat HIV?

Keziah: (smiling) Yes they should, and some countries are.

Julie: They should because they have the necessary resources and HIV is a pandemic?

Keziah: Yes. They seem happy to share things they can make money from, but don't want to share things like medications. They will not make money on these things. The western world can easily give, but I understand about donor fatigue and that they are tired of giving. Still, look at how much money has been spent on the war in Iraq.

Is it the process of being the other in another's world that changes us? Is it the process of seeing another cope in my world? Is my moral development after initially experiencing Ghana due to seeing the individualization and personalization of the known

suffering? If so, I further understand the critical nature of and need for intercultural dialogue in order to together find a common ground and space for new, mutual understanding. At home I interact with refugee families learning daily about their new home in Canada. As I travel through some learning experiences with them I also learn, valuable learning that couldn't occur without living the experience. These experiences often seem overwhelming due to the vast differences in our worlds. Hope and I discuss one such experience related to planning a program that the Sudanese women have asked for. They are keen to get together to learn about cooking in their new surroundings. It is through this experience that we increase our understanding of each other's world.

Hope: The women need some help with cooking. Many of them have only prepared meals on an open fire. They need to learn what to buy at the grocery store, and how to store and prepare it. Some of them have never used a refrigerator or oven before.

Julie: Any foods in particular? How do you think we should approach this? Should we demonstrate preparation of a certain food or should we go to the grocery store together and then prepare the food?

Hope: The women want to learn about Canadian food and food to send with their children for school lunches. We know about Sudanese food, we want to learn more about Canadian food, so at school, the children will have the right lunches and feel that they fit in.

Keziah and I also learned through conversation about some differences between us.

Julie: Growing up in North America, life is very comfortable. Due to our abundance of resources and our financial ability to purchase resources, on a global scale, we live a privileged life. While I appreciate being raised in such a setting, I have always wondered what life is like in the rest of the world, wonder how others experience their worlds.

Keziah: We live in an environment where things are not easy, there are vast differences in our ways of life and maybe this pushes you to learn and understand.

Julie: Yes, and I've realized, I think that I learn most when pushed out of my comfort zone. I learn more about that place I have come to and more about myself.

Influences

In her clinic work, I experienced Keziah in a respectful and responsible way, attempting to instill the same in her clients. At church, I heard a lot about obedience. Together with Keziah, I attended the Good Friday church service, respectfully enduring the faith message, celebration of singing and dancing and the sweltering mid afternoon heat for four hours, when Keziah, herself, suggests it was time to go. I experienced my body and my endurance being tested, being stretched beyond my existing limit, while at the same time, being in awe of the strength of faith and the meaning of worship.

We dialogued about the influences from churches, from society, and from the developed world, as they affected Ghanaians.

Keziah: I think we live in a society more driven by cultural traditions than you do. For example, you know we are very open here. Our extended family system is critically important to our culture. Although it still works, the extended family system has broken down slightly due to influence from the western world. Our feeling is that you live in a very individualistic society.

Julie: Yes, I think we live in an individualistic society. It is common in our country to live away from extended family. It didn't used to be like that, but is more so today.

Keziah: The role of women and men in our society is highly guided by and promoted through our societal norms. These norms are challenging to change.

Julie: I experience that to be true here in Ghana and like in every society, the accepted norms provide structure to the people.

Keziah: You have seen and learned about the influences of the church, particularly related to HIV, and to life in general. We have talked about voluntary HIV testing, but also, the church fills a huge role in people's lives here. You see a lot of women taking part in church activities, because at the end of the day, after being in church, jumping, laughing, singing, dancing, you can at least fall asleep. For the time being, you can feel better. So, you realize that our environment plays a major role in our behaviors, our way of thinking, and our decision-making, and the way we perceive things.

Julie: Yes, I understand what you are saying and I believe it is true within any culture or environment one is raised in. I guess that is part of the reason I want to experience other ways.

Theme 3: Cultural strength

Interacting with different cultures provides an opportunity to learn about and observe cultural traditions. As I did so through dialogue with Keziah and Hope, I was reminded of the strength of cultural traditions in one's life. This observation and understanding served to turn me back to my culture and examine my traditions.

Julie: I experience Ghanaian women to be incredibly strong, physically and emotionally.

Keziah: Yes, you are right. They are very strong, in the sense that you see a Ghanaian woman carrying their babies at their backs, going to the farm, cooking, planting, pounding, making fufu, carrying water, toiling, walking in the sun the whole day, selling, going to the market, bringing some produce to sell. On top of this physical strain, they are able to take care of their children somehow.

Julie: Against the odds, it would seem.

Keziah: Yes, it is challenging. Women are supposed to think and believe they play a subordinate role to the male. Society has brought about these rules. At your marriage you are told to do whatever your husband tells you to do. Be very obedient and humble and do not argue with him. Therefore, the man is brought up to think that he owns a woman. So you see, physically the women are very strong, but mentally they are sort of imprisoned.

Authority and personhood

Through my observations at the clinic, I sensed that Keziah and the nurses had a considerable amount of authority. Upon reporting my observations to Keziah it was explained to me that it is expected authority and knowledge as a professional nurse. Our conversation continued.

Keziah: I am considered an authority as a nurse, but sometimes being a woman is a barrier.

Julie: Would you give me an example of what you are saying?

Keziah: I had a male client who came to the clinic seeking advice related to sexually transmitted diseases. I helped him gather the information he wanted, the way I always do. The gentleman stated he was uncomfortable with the fact that I was a female and talking about sexual issues. He actually said, 'you are a nice person, why would you do this work'? I explained to him that this was my role as a professional who works in this area of health. The man could not overcome his preconceived cultural ideas of women speaking about sexual issues, and despite saying I had really helped him, he wouldn't be able to come back again.

Julie: Does that happen often?

Keziah: No, thankfully, I like to think that as a professional I can talk to anyone.

Following this conversation as well as many others, I thought of authority and power, as well as the relationship between the two. I also tried to understand this relationship within my own culture, as we conversed together. As written earlier in this document, my understanding of power was broadened by the words of J. Poling (1991), who says that power is relational. It encompasses the ability to both produce and experience an effect and is necessary to sustain a relationship. In its ideal form power is synonymous with life. The amount of power we each have is determined in relation to

others. Healthy relationships are those in which self and other are continually transformed. As each participates in the experiences of the other, the relationship is enlarged with the subjective reality of each individual enriched (Poling). I attempted to relate in my mind and in conversation with Keziah, how authority and power affected one's personhood.

Keziah: A nurse is expected to have knowledge and thus has authority in the clinic setting, while a wife is expected to be more subservient, unquestioning of her husband, and having little authority within the marriage. Sometimes you come across these women in the clinic who are sort of handicapped. They do not know what to do because they do not want to have more children. Some don't even want to have sex anymore, but they have to. As a nurse you are confronted with this and then you imagine yourself in that situation. When you strip away your nursing attire, you are a wife and a woman. The reality is that not many of us can negotiate for condom use.

Julie: I think I would find that very difficult, like I was living two lives, like I was two different people.

Keziah: Sometimes it feels like that, but that is our culture.

The church appeared to have authority over who it would marry according to HIV antibody test results. This seemed apparent to me in our conversations about voluntary HIV testing.

Julie: Can the churches actually refuse to marry someone who is HIV positive?

Keziah: The church can refuse to marry such couples. Often people test because they want to please the church elders.

Julie: What do you think the interest of the churches is in HIV? Are the churches interested in the health status of all their members, with all their health issues?

Keziah: They mean well actually, they think they have to protect their members from HIV infection. They do this by asking for testing, but

do not have any supports in place for those members who may test positive.

Through our conversations I could see the strength of cultural expectations and norms as the governing power and authority and how it seemed to confine but also comfort individuals. I wondered about my own cultural expectations at home and wondered if they were any different than what I experienced here? I thought of our own churches and whether they hold as much power and if they are any more supportive of people with HIV?

Obedience or respect?

I became more aware as we conversed about obedience that it seemed to be a key component of Ghanaian society, sometimes appearing to guide behaviors. In our conversations I learned that couples may test voluntarily for HIV antibodies in order to satisfy church leaders, to please the elders, women were told in preparation for their marriages to be obedient to their husbands. If a church member contracted HIV, they must have disobeyed God.

Keziah: Some of the church leaders believe that HIV is a curse from God. Because you disobeyed God, a curse is put on you.

Julie: Is obedience an important value in your society?

Keziah: Yes, with things that we have talked about already, but also, we would be considered disrespectful if for instance we addressed those older than us by their first names. As a Ghanaian you are expected to know that and behave accordingly.

I wondered if obedience was it driven by a sense of respect? I wondered what meaning was placed on these terms by this culture, as I also thought about what meaning they had for me. As I thought about this in my culture, I experienced respect and

obedience as separate phenomena, but was this really so? Here, in Ghana they seemed entwined. I wondered if respect was actually embedded and showed itself in obedience in the Ghanaian culture? It seemed obedience was considered respectful and I wondered about the implications this had for health education? Would health education information be followed if they respected the nurse providing it?

Experiencing Hope

Throughout all of our dialogue, I experienced Keziah in a hopeful way. She expressed hope for the future, without ever leaving the present moment. I was reminded of my tendency to think ahead and appreciated her gentle persuasion back to the present moment. This was illustrated in a beautiful moment, which we laughed about. As I attempted to organize further conversations for data collection the following short conversation occurred.

Julie: So what is next, what will we do tomorrow and when shall we try to converse again?

Keziah: (with a calm, wise expression) I don't know, we aren't 'there' yet, we'll decide what is next when we get there.

Julie: (laughing) Thanks, Keziah. Thank you for that.

She expressed hope at many levels; locally and globally and while we conversed about issues related to the clinic day, we often moved into discussions at a global level. Of course her daily concerns centered on the impact of HIV in Ghana, but we were both aware that global issues affected local efforts. We spoke about the rates of HIV infection being lower than in many other African countries.

Keziah: In Ghana, several years ago the government started showing a commitment to HIV/AIDS and this government is also continuing. In 2000, the Ghana Aids Commission was established under the office of the president as an intersectoral, multidisciplinary organization to guide the management of the disease in Ghana. We are working hard and are hopeful to keep our numbers under 5%.

Julie: Here I see extraordinary efforts and lots of hard work to control HIV/AIDS rates in Ghana. Everything I hear about, see you doing is really hard work and you are doing it without the support of anti-retroviral medications.

Keziah: We are hopeful for the imminent arrival of anti-retroviral medications. We are hopeful that money from debt relief will be used appropriately by the government, for education and health.

Julie: Channeled into areas like medications, specifically anti-retrovirals?

Keziah: Yes, to support the people who unfortunately are infected with HIV.

What is the future if there is no present or if we decide not to reside in the present? When Keziah and I discussed the future, it was always in a tangible way. I conversed about my sense of awe in Keziah's willingness to stay in the moment, no matter how devastating and difficult it was as she lived such pain and challenge in her professional work and I wondered what it was that made one hopeful amidst the pain?

I also experienced Hope in a similar manner. Despite the daily struggle of life, she spoke of looking forward to more education and help in her work with the Sudanese families. Interacting with both of them helped me think about my sense of hope and I wondered if I thought as hopefully as they both did.

Theme 4: Education: Investing in the future

Women and Education

As Keziah and I conversed, we quickly noticed how often education became a central part of the conversation. We spoke of women and education and the apparently clear connection between lack of education, cultural norms and the role of women in society. These conversation pieces were also a central part of conversations with Hope. In conversation, Keziah shared a well-known phrase with me.

Keziah: I'm sure you have heard this saying. If you educate a man, you educate an individual. If you educate a woman, you educate a whole nation.

Julie: No I have not heard that before, but I think it is a wonderful saying.

Keziah: Yes, and this is very true in our society. Men are always out somewhere, either working or doing something else. The women are the ones raising the children.

Julie: So, you are saying the mom is the consistent influence in the child's life?

Keziah: Yes, so we are encouraging the education of women, for we believe that when women are better educated, some challenges that individuals, families and communities face; the nation faces, would be far less.

Julie: I think this is a fair statement to make, and maybe to make about any nation, my own included.

We continued to converse about women in each of our societies and agreed that if women were educated, they would hopefully feel more empowered, and have stronger voices to make informed choices for themselves and their families.

Keziah: Women's main challenge has been with empowerment, educationally. Women are supposed to think and believe they play

a subordinate role to the male. Right from infancy, the girl learns roles like cleaning the house, looking after siblings, cooking, sometimes having to stop schooling to fulfill these roles. Meanwhile the boys are outside playing and going to school. This is our society.

Julie: In Canada, education for girls and boys alike is mandatory, by law, until the age of 16 years. This at least gets girl children part way through secondary education. There is also more emphasis these days on encouraging girls to continue their education in areas previously thought of as dominated by males, such as maths and sciences. I wonder if without this law, we might face the very same issues that you face here in Ghana.

Keziah: Women without education are at terrible risk. Sometimes traders who travel with their goods don't have places to sleep. They may have to sleep with someone for economic survival.

Julie: Do you think economic issues always relate directly to education?

Keziah: Yes, without education, you cannot make much of a living, and that leads to other problems related to health.

I became interested in the current government's dedication to the education of girl children in Ghana. Keziah explained that the current government was very dedicated to girl-child education and had named a department and female minister to lead it. The role of this new department was to empower women and girls, primarily through encouraging continued education.

Receiving education in Canada

In conversations with Hope, education was a common topic. As newcomers to Canada, refugees are keen to learn the language in order to gather more education and secure gainful employment.

Hope: One of the biggest hopes we have coming to Canada is to get a good education for our children and ourselves. It will ensure a better future for us.

Julie: At home in Sudan do children attend school?

Hope: Due to the war, which has existed for many years, many children have missed out on education.

Julie: Did you go to school as a child?

Hope: Yes, I remember Sudan when it was not at war. I also went to university in Egypt. I had a Muslim name so had an opportunity for education in the North.

Julie: Do you have education goals here?

Hope: Yes, I want to be a nurse, but right now my English needs more work to be able to keep up in class. I have taken some classes but not enough yet. I would like to be the first Sudanese to graduate as a nurse. When you have an education, you have many more choices and can have a good future.

Julie: In your work as a health broker with the Sudanese community are you asked to provide translation when it is needed?

Hope: Yes, so I practice speaking a lot. It is my writing that needs practice.

HIV/AIDS education

On a daily basis, the barrage of HIV/AIDs education programs hit me through radio, television, and billboards, in the clinic and in schools. They were comprehensive and gutsy, dealing openly with a sensitive subject matter. Keziah told me about a program, which appeared on television recently.

Keziah: This program is on every Tuesday in the local language. The hostess talked about HIV/AIDS this week and it was perfectly timed right before Easter weekend. Some individuals travel to their home towns to celebrate Easter and they are involved in all kinds of activities, particularly if drinking is involved.

Julie: That sounded like a very good program, bold in its message. I have never seen a show like that in Canada.

Keziah: The program was geared to prepare the minds of those about to travel for celebrations. The message is that HIV is on the corner, all around you.

Julie: It seems like a social marketing approach. The right message at the right time in the right place.

Keziah: Yes, it's very good. It helps me do my job. We now have been successful in educating the large majority of the population about HIV/AIDs. Now the bigger challenge looms before us, as we tackle the challenge of educating and supporting people to make changes in their behavior. Translating high awareness into desired behavior change is now the main challenge.

In further dialogue, we talked about HIV as a developmental issue in the world and social and cultural factors, which affected attempts at health education.

Julie: HIV is a social, economic and political condition in the world.

Keziah: Yes, I agree and in our environment we have an added challenge. People commonly attach superstition to this issue. In our culture, superstition is common.

Julie: When I was here three years ago, I remember a woman receiving her positive HIV status results by saying, she wasn't surprised because the spirit had brought her the illness. Is that a common response, in your experience?

Keziah: One of my clients from a few years ago was told by a spiritual healer to bring a goat. He would make the HIV come out of him and go into the goat; the goat would die and that would be the end of the HIV infection. The man believed it, and despite having little money, bought the goat. Who knows what happened to the goat, but the man died.

Empowerment

Freire's work on empowerment education characterizes empowerment not as gaining power to dominate others but gaining power to act with others to effect change (Wallerstein & Bernstein, 1988). The writers present Freire's belief on the purpose of education. They say, "the purpose of education is human liberation, so that people can be

subjects and actors in their own lives and in society" (p.382). I understand the magnitude of this statement, after experiencing this living example of the value of HIV education in Ghana. I am also thoughtful about the importance of understanding cultural ways; meanings attributed to concepts such as respect and obedience in order to understand the role of education. Dialogue becomes the only way to reach a shared understanding, and to avoid the prescription of western ways, related to health education.

Keziah and I conversed about the abundance of peer education programs throughout Ghana, related to HIV and women's issues. I told her about Stephen Lewis, the special envoy to HIV/AIDS at the United Nations, who came to speak last year at our university.

Julie: In Canada, Stephen Lewis talks openly about the tremendous grassroots HIV peer education programs throughout Africa.

Keziah: We have many such programs, involving teens and adults as well as men and women. They provide education through songs, dancing and meeting with their peers.

Julie: Do you find this educational approach by training peer groups to be effective?

Keziah: Very effective, especially in the rural areas, where there are not many professional health care workers. Many people also respond better to peers than to professionals and we find people who become involved as peer educators are very committed to helping.

Summary

While the conversational transcripts were lengthy in nature, in this chapter selected excerpts served to illustrate both the content of the dialogues and the themes of the dialogue emanating from this study. Due to the confidential and intimate nature of some of the content of the dialogues given the research questions, it was important to be

extremely respectful of what is written here and to be very attentive to statements that could objectify either culture in this document. The themes presented were the Embodied Experience of Life, Money makes the world go around, Cultural Strength, and Education: Investing in the future.

CHAPTER 4: REFLECTIONS ON INTERCULTURAL DIALOGUE

> " Through interaction and dialogue we influence each other's world. Without more knowledge about how dialogue enhances understanding, we are less tolerant of what we do not understand, become less familiar with diversity and difference, and settle into a more dehumanizing environment" (Meleis & Im, 1999).

This thought from Meleis and Im guided me as Keziah and I, and Hope and I, conversed and through dialogue grew to understand each others worlds more fully and authentically. We learned about how each viewed the others world and added new knowledge and understanding to our preexisting knowledge.

Respect

Samovar, Porter and Jain (1981) define intercultural communication as a unique form of interaction that must consider the role and function of culture. As different cultures enter into dialogue they must strive to find commonalities within diversity. It is the commonalities that enable us to establish rapport and a relationship, even though we are more likely to focus on differences. In the conversations of this study, we discussed the term intercultural; acknowledging that it encompasses a variety of cultural differences based on religion, tribal backgrounds or family heritage, language, geographical location, age, and gender. We talked about what it was that allowed us to communicate across all of these differences and the first suggestions are respect, sensitivity and non-judgmental attitudes. Keziah added that in her clinic work respect is the most important component of intercultural dialogue, through acceptance of the person as they are, no matter who they are.

In Barrera and Corso's work on cultural competency in education, they suggest that the willingness to develop respectful, reciprocal, and responsive relationships through dialogue is the true measure of cultural competency. Respect involves suspending the need to impose one experience of reality over another. Reciprocity seeks to balance power between people in dialogue, while responsiveness is an openness to allow others to reveal who they are (2002).

Through this research I learned that there is a universal conceptual understanding of respect for all based in human rights and human dignity. But I also learned that there is a situated understanding of respect as well. It is truly a looking again as Dillon (1992) writes, engaging in the present moment, and I would add, that it also includes a looking backward and a looking forward. Looking back allows me to see if I have been fully respectful in the moment, given the moment what it needs and deserves. Respect is situated and negotiated and enacted in a culture in any moment of time.

Remen (cited in Barrera & Corso, 2002) says, "knowing where we are going encourages us to stop hearing and seeing. This pre-knowing allows us to rush ahead to our destination applying the same behaviors and understanding to all people. In culturally diverse situations we are challenged to recognize that a person is always more than and often different from our idea about whom they are. In relation we must refuse to reduce reality to a limited space" (p. 289). Keziah, Hope and I converse about our learning through interaction with other cultures and stressed that judgment gets in the way of potential learning. It closes the door to expanding one's horizons of understanding. Being judgmental makes a statement that we have nothing to learn from the other. I learned from Keziah that respect within her culture sometimes carries

different expectations than respect between our two cultures. She explained that when I am in Ghana it is acceptable for me to call someone senior to me by his or her first name. This is not acceptable within Ghanaian culture. I learn that I am excused because as a visitor I am not expected to know Ghanaian cultural norms to the extent that a Ghanaian is expected to know.

Power

Prior to visiting Ghana and prior to working closely with other cultural groups in Canada, I was certainly aware of the fact that power affects relations in a multifaceted way. To deny or underestimate its magnitude and effect on dialogue and emerging relationships would be neglectful and unrealistic. The existence of power in relations is a fact of life and may be the single biggest factor affecting intercultural relations. Throughout our conversations I tried to be mindful of the many facets of power, attempting to imagine how they might show themselves through the process of this study.

Through the conversations, the power of globalization, of North American economic dominance, and therefore the power I might have as a Canadian in this situation became apparent. The power that comes with authority was visible with all of us at different situational moments in time. As nurses, we have some authority with our clients and through our work as helpers at times we hold formal or informal authoritative positions. As I have learned from Poling (1991) that power is relational and I see it and hear it through our conversations.

Tangwa (1996) tells us that knowledge is power and that the western world believes their knowledge to be the most powerful. I am reflective about my knowledge of

the history of colonialization and how power and authority gave to some and took from others. I am thoughtful while in Ghana of the continued effect of that piece of history on our potential relationships. While I attempt to be thoughtful and aware of power and how it shows itself, I also realize that I can only be sensitive to and realistic about the multidimensional role of power in intercultural relations and not try to control it or compensate for it.

Face to face

Levinas (cited in Nortvedt, 2001) speaks of the importance of relational proximity and face to face encounter as the starting point of any relationship. He says, "everything starts from the face, from the responsibility for the other" (p.115). Through our conversations, Keziah and I, and Hope and I experienced immediacy and presence in face to face interaction and we seemed to feel a sense of responsibility for each other in our communication. I saw that when I moved too far forward towards something as intangible as the future, they brought me back to the present, to the reality of the moment. In dialogue, we recognized the other, as well as recognizing our selves. Recognition and celebration of each other opens the door to building a relationship, of each expanding what we know and experience at that moment. When conversing about the experiential value of being in Ghana, learning through daily, authentic experiences in and out of the clinic we acknowledged that there is not only a recognition of the other through face to face interaction, but celebration of similarities and differences. One must be willing to enter and dwell in the relational space, encouraging and accommodating diversity, and through dialogue see the potential for shared understanding to develop in this space. Commitment to staying in the relational space encourages learning about each other's

"living I" and through the "living I" we acknowledge that each other has inherent knowledge (Bergum, 1996). Through this acknowledgement we are more likely to be respectful and less likely to impose our own realities on each other.

Staying in the process

On a daily basis we lived together in the midst of suffering and distress in the clinic. Despite being exhausted, hot and hungry, the day was far from over, as we needed to meet together to converse and address our questions. Yet we were committed to staying with this process, not abandoning the difficult questions, and coming up with the time and stamina we found that intercultural dialogue requires. Despite feeling overwhelmed at times, together we chose the way that did not allow us to narrow the world, to have a handle on our understanding. Gadamer (1989) says, " To conduct a conversation means to allow oneself to be conducted by the subject matter to which the partners in the dialogue are oriented....to question means to lay open, to place in the open" (p.367). This increases our awareness and understanding of each other, but also shows us where our prejudices are, our preconceptions about each other and together we build a new, shared understanding. In dialogue, we explored new thoughts through the other. We learned and expanded our worldviews. I wonder whether we became more authentic, more engaged, and more accountable, responsible to the other in face-to-face interaction? I do feel that the immediacy of the face is the only way to acquire true experiential learning, as I have expressed above.

Chen and Starosta (2000) tell us that as our world becomes more interdependent, we will experience more face to face interaction with people of diverse ethnic, religious,

cultural and social backgrounds. We will need to develop a more global mindset where we see things through the eyes of others, adding their knowledge to our existing knowledge. Only through competence in intercultural communication will this be possible. When Hope and I talked about her communication with Canadians, what I heard was that sometimes people understand what she is saying and sometimes they do not understand. Some people try to make their language simpler and some seem not to care whether you are understood or have understood a conversation. She was quick to say that it is not that people don't care, it is that they lack experience talking with people of other cultures. Gathering experience talking with or working with diverse cultures is essential to success in communication.

In all conversations we talked about traditions and openly discussed traditions we each have as members of a cultural group. We discussed whether our knowledge and feelings about others traditions affected our ability to dialogue about them. To help someone understand another's attitudes and feelings regarding traditions, they must first understand their own values and have developed some level of self-awareness. We agreed that instead of judging another tradition, it is best to learn about it, developing respect for diversity and to resist judgment. Keziah added that learning anything new removes ignorance, it broadens your outlook and your mind. When your mind is open, you are less inclined to judge others. I think about the commitment that is required to engage in intercultural dialogue.

Commitment in intercultural dialogue is multi-faceted. One must be committed to learning about another culture; their beliefs and experiences in the world. One must also be committed to self-learning, about one's own culture, beliefs and experiences in the

world. Finally, commitment to staying with each other in a process of emerging understanding as well as the occurrence of perpetual self-transformation; a finding of oneself in relation to others (Smith, 1994).

Expanding our horizons and self awareness

Following my two visits to Ghana, I see the world more interdependently than I did previously. I see it as one entity. Ghana, a developing country has issues that affect us, while our issues and actions in the developed world affects Ghanaians. The possibility or reality of living in isolation is no longer possible. I am more attentive to the historical events of the past and know we have not truly critiqued our historical colonial ways. I continue to experience this daily in my work with refugee families and am grateful for the reminder.

I think about my call to Ghana and wonder if it is about the universality of global issues and my need to understand them from many different perspectives? Are issues such as education, maternal and child health, and the relationship of economics and health common to most countries in the world? I experience these issues in my own culture as well as in other cultures. Is it less about the issues and more about how the issues are managed within each culture and country and the reasons for that? This question leads me to whether or not we are drawn together by similarities or differences. Repeatedly through dialogue, Keziah and I experienced many similarities that drew us into relation, and my sense is that we thought we were more different than we really were.

Hope and I conversed about marriage traditions and the role of women in marriage. In her culture, driven by the pride of having a large family, each wife in a polygamous marriage holds the responsibility of choosing the next wife, assuming different roles according to succession number. I was fascinated with the differences between our cultures and learned so much through our conversation. I felt as though my mind had been broadened in a wonderful way. O'Driscoll (2001) warns us about the western tendency for developing monoculturalism. We must change our thinking that intercultural communication and diversity is associated with conflict. For some reason, he explains, we think that in order to gain ability in intercultural communication, we might lose something. He challenges us with the question, "Why are we afraid if we expand our horizons of language and culture we might lose who we are?" (p.488). It is only through dialogue that we increase our individual and collective understanding. It expands our horizons and opens our minds to the outside world. It is only through relation to others that one's horizons of understanding are expanded.

In conversation, Keziah and I discussed what it is like for her when the Canadian nursing students come to her clinic. I conversed with her about my observation that the nurses in the clinic, due to limited resources must be very creative, improvising ways of delivering care to their patients. I thought about nursing at home and wondered with comparatively abundant resources whether we lose the need to be creative. Keziah says that when nursing students from Canada come to the clinic to participate in a practicum experience, she is amazed and pleased with how quickly they learn different and often creative ways to assist in the delivery of care. I think about this and wonder if a key component of intercultural dialogue is the opportunity to learn new ways, to simply invite

alternate ways of knowing, thinking and doing. Is it also something about nursing as nursing constantly seeks ways to deal with the particular person in a particular set of circumstances.

Charles Taylor (1991) speaks of the western value of individualism, and helps us understand that by centering on the self, we narrow our lives, we become less concerned with the other, and our aspiration in life becomes the acquisition of comfort. I experienced much discomfort in Ghana. I was away from all my usual comforts, materialistic and human. Heat, hunger and loneliness prevailed, and I found that my greatest learning and openness occurred at this time. Keziah and I conversed about this and agreed that a sense of comfort perhaps allows us to relax our learning potential. In conversation, I offered my opinion that on a global scale, life in North America was comfortable. We have a very high level of accessible health care, we have resources; we have all we need and more. Since my first visit to Ghana I have thought a lot about learning and comfort. It seems to me that it is through the discomfort, physically and emotionally that I learn so much. I would say I learn more when pulled from my comfort zone. Keziah agreed that we all probably learn more when pushed out of our usual comfort zone and reflected on this thought by thinking about what it would be like for her to live in an environment like mine. While she thought it would be easier in some ways, it might feel strange. She acknowledged the openness of the Ghanaian people and the strength of the extended family network and commented that she might be very challenged living in an individualistic environment like mine.

Recognizing and allowing vulnerability in oneself and others is also important in intercultural dialogue. A sense of vulnerability is created when leaving the comfort of

what one knows and understands to go to what one does not know or understand. Staying with the vulnerability in the present moment helps us not to be tempted to apply theory as much. Perhaps in this vulnerable state willingness for self-transformation occurs. As well, being committed to the bodily experiences of health and illness in another culture allows an opportunity to learn through our vulnerability.

Gudykunst and Kim (1984), in their work on intercultural communication say that due to our inseparable relationship with our culture, and due to the fact that we are all culturally programmed to think and act like those similar to us, we find different behavior as strange, improper or inferior. Hall (1984) says that the process of understanding ourselves and understanding others are closely related. He feels that our real job is not to understand foreign cultures, but through exposure to them, it is to understand our own. This exposure generates a sense of awareness, a sense of vitality for life, which comes as one experiences difference. Reflection on this thought and my experience with this work, tell me that increasing self awareness of one's own culture is one of the key benefits of developing intercultural relations through dialogue.

Identity and objectifying the other

Keziah explained to me that before, the Africans used to have their own culture, but now have lost some of their identity to the West. We conversed about the Western influence on Ghanaian identity, as well as one's own identity within their culture. I learned from Keziah that her identity related to her role as a nurse was strong. I experienced in observing her interactions that she is regarded as a compassionate, helpful expert in her field of HIV/AIDS in Ghana. She has received training in her field of

counseling, and in her non-judgmental, sensitive way, is respected by her clients. I questioned my identity, as a Canadian, a nurse, and a woman as well as my identity here in Ghana. How did I use my personhood or identity to enter into dialogue? What was it I brought and why?

Through the process of dialogue, we hope not to objectify the other. The intent of this work was to learn how not to turn the other into an object, how to listen to one's self, how to question and respond to the subject matter. We endeavored to focus on engaging in the conversations, in the actual dialogue as opposed to focusing entirely on the content or product of the conversations.

Responsibility in intercultural dialogue is required on many levels. One must be have full responsibility to being present and engaged in so many aspects of reality, one must be a responsible global citizen, and there must be responsibility for each other in dialogue. Levinas in Nortvedt (2001) speaks of relationships beginning with face to face proximity and a sense of responsibility for the other. Dillon (1992) reminds us that in relation, we must account for our connectedness, our distinctness and our interdependence. It is also critical in this study, that I be responsible for the respectful representation of my own and another culture.

While I am a strong believer in learning authentically through experience, I acknowledge the important role literature and theoretical knowledge play in our learning. Ensuring both components will guard against objectifying and reducing reality, especially important in intercultural dialogue and relationships.

Intercultural dialogue is difficult to live authentically, truly, and consistently. This work has provided me with some insight into why it is so difficult, and alternately why we can easily, though not consciously, objectify the other in intercultural situations. There is always a tendency to embrace preconceived ideas and theorize about culture rather than to just be there in the situation, to be there in the body with them. There appears to be the pull to cross the line, to feel tension in intercultural dialogue. In my western ways, I try to develop further understanding about intercultural communication through dialogue with other cultures. I also observe Keziah in these tensions, during communication with a Canadian as well as in her clinic with different cultural groups from her own country. Is intercultural dialogue really about the willingness to stay with the tensions and unknowns?

CONCLUSION

"There must be something midway between the inauthentic and homogenizing demand for recognition of equal worth, on the one hand, and the self- immurement within ethnocentric standards on the other. There are other cultures and we have to live together more and more, both on a world scale and co-mingled in each individual society" (Taylor, 1994, p. 72)

At the beginning of my thesis work, I imagined a quest for knowledge, the results of which I would offer to the world with some definitive answers to the questions I had proposed to research. What I feel I have at the end of this process is increased awareness, more questions than answers, and a renewed need to continue learning. I also know that in order to engage in intercultural dialogue one must know oneself very well and be committed to learning about oneself.

Intercultural communication requires openness and a willingness to stay present in the process, through differences, similarities and unknowns. A script worked out a priori cannot guide us through the process without threatening objectification. The complexity of intercultural work and dialogue are immense, but this immensity should not deter us from working toward greater understanding. Respect and acceptance are paramount to the development of responsive and reciprocal intercultural relationships. It is important to understand that while respect is a universal concept, it is also situated and enacted in cultures different ways at different times.

Dialogue which involves face to face interactions with people of different cultures helps to promote a sense of responsibility for each other. Intercultural communication also requires commitment; commitment to enter the relational space, to remain in the

space in the process of discovery until shared understandings develop and new horizons of understanding emerge. Clearly, in dialogue and interactions with other cultures we expand our cultural understanding, however, more importantly, we have the opportunity to increase our knowledge about ourselves and our own culture. Understanding that power is relational is fundamental to intercultural work. Finally, keeping a sense of vulnerability in our presence and communication encourages us not to theorize about or objectify the other.

Hermeneutic methodology provided a way to explore intercultural dialogue as it calls us to understand something from all sides. It is a way to bring things into view and increase our understanding of ourselves. Knowledge is not acquired and applied, but rather shared understanding emerges through the commitment of staying with one another in the process. Hermeneutic analysis increases our understanding of particular situated circumstances as well as universal, global circumstances. Gadamer (1989) reminds us that the answer to any question is not found in the expertise, but in dialogue where the other half of the understanding is found.

Nurses are mandated to provide culturally competent care in a changing and increasingly intercultural world. Nurses must become aware of how dialogue enhances understanding and gather experiences, which will support them in working toward becoming more tolerant of cultural diversity and difference. Historically nursing has operated within multicultural work by developing cultural assessment tools, designed to gather information about a client from another culture. While these tools are very helpful to nurses, they must be used as a guide only and not as a replacement for dialogue and relation building with our multicultural clients.

Nurses are in a privileged position, providing care to all people regardless of their cultural heritage and circumstances. Nurses must seek out experiences in their own country or in another country to interact with other cultures, to be present with the experience, to develop trust in their ability to be attentive and to learn about self and other in the process. A multitude of individual multicultural experiences will gradually increase understanding and acceptance at a broader level within our profession.

Educationally, nursing curricula must reflect the multicultural nature of our society. Nursing students of all levels need opportunities to interact with other cultures in practice settings through clinical course placements.

Intercultural dialogue is an area of study that is complex and multi-factoral. Many of the themes and components of intercultural dialogue identified in this work, warrant full studies themselves and therefore, acknowledgement is made that this work is a beginning look at the nature of intercultural dialogue. My hope is that nursing will continue its quest for knowledge in the area of intercultural dialogue. In the end, I know that in exploring intercultural dialogue, in reality, I have also investigated my own culture. I have come back to my own place in the world, with new insights and understandings.

" The world is round and the place which may seem like the end may also be only the beginning" (Priest, 1995).

REFERENCES

Attaran, A. & Gillespie-White, L. (2001). Do patents for anti-retroviral drugs constrain access to AIDS treatment in Africa? Journal of the American Medical Association 286(15), 1886-1892.

Baker Priest, I. (1995) In. S. Breathnach, Simple Abundance: A Daybook of Comfort and Joy, New York: Warner Books, Inc.

Barrera, I. & Corso, R. (2002). Cultural competency as skilled dialogue, Topics in Early Childhood Special Education 22 (2), 103 – 115.

Benetar, S.R. (2002). Expanding the discourse on ethics: Towards reducing disparities in health. Keynote address, G6B Summit, Kananaskis, Alberta. Retrieved from www.g6bpeoplessummit.org/ab/benetar.html

Bergum, V. (1989). Being a phenomenological researcher,(ch.4). In J. M. Morse (ed.) Qualitative Nursing Research: A Contemporary Dialogue. Maryland: Aspen Publishers.

Bergum, V. (1992). Beyond rights: The ethical challenge, Phenomenology and Pedagogy 10, 75-84.

Bergum, V. (1994). Knowledge for ethical care, Nursing Ethics 1(2), 71-79.

Berlinger, G. (1999). Globalization and global health, International Journal of Health Services, 29(3), 579-595.

Bhabha, H. K. (1994). The location of Culture. London: Routledge.

Browne, A. (1993). A conceptual clarification of respect, Journal of Advanced Nursing,18, 211-217.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery Of healthcare services: A model of care, Journal of Transcultural Nursing, 13(3), 181-184.

Chen, G.M. & Starosta, W.J. (2000). Eds. Communication and Global Society, New York: Peter Lang Publishers.

Dillon, R.S. (1992). Respect and care: Toward moral integration, Canadian Journal Of Philosophy, 22(1), 105-132.

Douglas, M. (2002). Developing frameworks for providing culturally competent health care, Journal of Transcultural Nursing, 13(3), 177.

Dreher, M. & MacNaughton, N. (2002). Cultural competence in nursing: Foundation or fallacy? Nursing Outlook, 50(5), 181-186.

Erlin, J.A. (1998). Culture, ethics, and respect: The bottom line is understanding, Orthopedic Nursing, Nov/Dec., 79-82

Gadamer, H.G. (1989). Truth and Method (2nd revised ed.), J. Weinsheimer & D. Marshall (Trans.). New York: Crossroads.

Gadow, S. (1999). Relational narrative: The postmodern turn in nursing ethics, Scholarly Inquiry for Nursing Practice: An International Journal, 13(1), 57-70.

Gudykunst, W.B. & Kim, Y.Y. (1984). Communicating With Strangers: An Approach to Intercultural Communication, Don Mills, Ontario: Addison- Wesley Publishing.

Hall, E.T. (1984). The Silent Language, Ch. 2, New York: Doubleday & Company.

Henson, R.H. (1997). Analysis of the concept of mutuality, Image: The Journal Of Nursing Scholarship, 29(1), 77-81.

Jardine, D. W. (1992). The fecundity of the individual case: considerations of the pedagogic heart of interpretation, Journal of Philosophy of Education 26(1), 51-61.

Karaban, R.A. (1991). The sharing of cultural variation, The Journal of Pastoral Care, v.XLV (1), 25- 34.

Leininger, M. (1978). Transcultural Nursing: Concepts, Theories, and Practices. New York: John Wiley & Sons.

Leonard, V. W. (1994). A Heideggerian phenomenological perspective on the concept of person, In P.Benner (ed.). Interpretive Phenomenology. Embodiment, Caring and Ethics in Health and Illness. Thousand Oaks: Sage Publications.

Lewis, S. (2001). "Global citizens making globalization work". Keynote address International Week, University of Alberta, Edmonton, Alberta.

Little, C. (1992). Health for all by 2000: Where is it now? Nursing and Health Care 13 (4), 198-201.

Meleis, A. (1996). Culturally competent scholarship: Substance and rigor, Advances in Nursing Science, 19(2), 1-16.

Meleis, A. & Im, E. (1999). Transcending marginalization in knowledge development, Nursing Inquiry 6, 94-102.

Merriam-Webster Inc. (1984). Webster's Ninth New Collegiate Dictionary. Markham Ontario: Thomas Allen & Son, Ltd.

Morse, J.M. (!988). Introduction, Recent Advances in Nursing: Issues in Cross-Cultural Nursing, 20, 1-6.

Nortvedt, P. (2001). Needs, closeness and responsibilities. An inquiry into some rival moral considerations in nursing care. Nursing Philosophy, 2, p.112-121.

O'Driscoll, J. (2001). Hiding your difference: how non-global languages are being marginalised in everyday interaction. Journal of Multilingual and Multicultural Development 22 (6), 475-489.

Olthius, J. H. (2000). Exclusions and inclusions: Dilemmas of difference, Towards an Ethics of Community: negotiations of Difference in a Pluralistic Society. Waterloo: Wilfred Laurier University Press.

Poling, J. (1991). The Abuse of Power: A Theological Problem, Nashville TN: Abingdon Press.

Robertson- Malt, S. (1999). Listening to them and reading me: a hermeneutic approach to understanding the experience of illness, Journal of Advanced Nursing 29(2), 290-297.

Roy, A. & Starosta, W.J. (2001). Hans-Georg Gadamer, language, and intercultural communication. Language and Intercultural Communication 1 (1), 6-20.

Ruiz, P.O. & Minguez, R. (2001). Global inequality and the need for compassion: Issues in moral and political education, Journal of Moral Education 30(2), 155- 172.

Sachs, J. (2001). Macroeconomics and Health: Investing in Health for Economic Development, Report of the commission on macroeconomics and health, World Health Organization, Geneva.

Samovar, L.A., Porter, R.E. & Jain, N.C. (1981). Understanding Intercultural Communication, California: Wadsworth Publishing Company.

Shi-Xu & Wilson, J. (2001). Will and power: Towards radical intercultural communication research and pedagogy, Language and Intercultural Communication 1(1), 76-93.

Smith, D.G. (1994). The hermeneutic imagination and the pedagogic text. In E. Short (Ed.), Forms of Curriculum Inquiry. New York: SUNY Press.

Smith, D.G. (2003). The Mission of the Hermeneutic Scholar. In M. Wolfe (Ed.) The Mission of the Scholar: Essays in Honor of Nelson Haggerson. Mahwah, NJ: Lawrence Erlbaum.

Streubert, H.J. & Carpenter, D.R. (1999). Qualitative Research in Nursing: Advancing the Humanistic Imperative (2nd ed.) Philadelphia: Lippincott.

Tangwa, G.B. (1996). Bioethics: An African perspective, Bioethics, 10(3), 183-200.

Tangwa, G.B. (2000). The traditional African perception of a person: Some implications for bioethics, Hastings Center Report, September/October, 39-43.

Taylor, C.A. (1993). Positioning subjects and objects: Agency, narration, relationality, Hypatia, 8(1), 55-80.

Taylor, Charles (1994). The politics of recognition. In Multiculturalism: Examining The Politics of Recognition. A. Gutman (ed), New Jersey: Princeton University Press, 25-74.

Van der Zalm, J.E. & Bergum, V. (2000). Hermeneutic-phenomenology: providing living knowledge for nursing practice, Journal of Advanced Nursing, 31(1), 211-218.

Van Manen, M. (1997). Researching Lived Experience: Human Science for an Action Sensitive Pedagogy. London, Ont: Althouse Press.

Velasquez, & Boulet, (1999). Essential drugs in the new international economic Environment, Bulletin of the World Health Organization, 77(3), 288- 291.

Wallerstein, N. & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. Health Education Quarterly 15 (4), 379-394.

Wheatley, M. (2002). Turning to One Another: Simple Conversations to Restore Hope to the Future. San Fransisco: Barrett-Koehler Publishers, Inc.

APPENDICES

Appendix 1: Information sheet # 1
Appendix 2: Information sheet # 2
Appendix 3: Information sheet # 3
Appendix 4: Consent form # 1
Appendix 5: Consent form # 2
Appendix 6: Consent form # 3
Appendix 7: Information sheet # 2 and Consent form # 2 in Twi
Appendix 8: Ethical approval letter – University of Alberta
Appendix 9: Ethical approval letter – University of Ghana

Appendix 1: Information sheet # 1

UNIVERSITY OF ALBERTA

Information Sheet # 1 – Ghanaian Nurse

Intercultural Dialogue: The Call of Africa Lives With Me Still

INVESTIGATOR:
Julie A Gilbert RN, BScN, MN (c)
Faculty of Nursing
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Edmonton, Alberta, Canada
(780) 430-7261

CO-INVESTIGATOR:
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Associate Professor, Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 492-6412

PURPOSE OF THE STUDY: You are being asked to take part in a research study. The purpose of the study is to explore communication between different cultures. We will have conversations about issues related to health care.

BACKGROUND: Canada is a multicultural nation, where people of diverse cultural background live together. In health care settings nurses must communicate with, care for, and understand people of diverse cultures. By having conversations with people of a variety of cultural backgrounds, nurses have the opportunity to learn about their own and other's cultural experiences. Through conversations we hope to understand some of the areas that influence communication.

PROCEDURES: Taking part in this study will involve:

1. Participant observation: I will observe your activities with clinic patients who consent to my being present with you.
2. At the end of the day, we will choose a health topic from the day and together we will decide on which topics to discuss in our intercultural dialogue.
3. Audiotaped conversations: I will be inviting you to participate in an intercultural dialogue around the topics we have mutually decided on to discuss. There will be from 7 – 10 conversations of intercultural dialogue.
4. Each conversation will last up to one hour.

VOLUNTARY PARTICIPATION:

BENEFITS: This study may have no direct benefit for you. I hope to understand better what is required for effective communication between cultures.

RISKS: There are no known risks to your participation in this study. Respect for your privacy will be my priority at all times. You may request no tape-recording at any time.

CONFIDENTIALITY AND ANONYMITY: .All information will be held private. I will keep tapes and written material from the study in a locked filing cabinet at Mamprobi Clinic for a period of five years. I will delete your name from all the records. Your real name will not be used. Consent forms will be stored separate from the tapes. I will do my best to keep your identity and information confidential, but because of the small number of participants it may be possible for you to be identified. We will review the data together to be sure you are comfortable with how the information is being presented. You can choose to remove any quotes you have made at that time.

FREEDOM TO WITHDRAW:. During the conversations and participant observation you do not have to discuss any subject you do not want to. You may withdraw from the study at any time without consequence to you personally.

FUTURE USE OF DATA: .I may present findings from this study at conferences. I may also publish some of the findings. You will be invited to co-author any publications.

ADDITIONAL CONTACTS:
Dr. Brenda Cameron – (780) 492-6412

Dr. Kathy Kovacs Burns – (780) 492- 3769

Appendix 2: Information sheet # 2

UNIVERSITY OF ALBERTA

Information Sheet # 2 Mamprobi Clinic Patients

Intercultural Dialogue: The Call of Africa Lives With Me Still

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CO-INVESTIGATOR:
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PURPOSE OF THE STUDY: I am a nurse from Canada. I am in Ghana to learn about working with people from different cultures. I will be with your nurse as she provides your care. I will not be providing your direct care. Afterwards, I may be talking to your nurse about your health concerns. We may talk about how we can make it easier for people from other cultures to talk together about health concerns.

By talking with other nurses we can learn more about our experiences. By talking together we want to understand areas that help us talk to people from other cultures.

PROCEDURES:

1. Another nurse will explain the study to you. She will ask for your written or verbal consent for me to be with your nurse as she provides your care.
2. Afterwards, your nurse and I may talk together about the health and cultural concerns from the visit. All this information will be kept confidential between your nurse and myself.
3. If you do not want your health concern to be discussed, you can let us know and we will not discuss it.

VOLUNTARY PARTICIPATION:

BENEFITS: This study may have no direct benefit for you. I hope to understand better what is required for effective communication between cultures.

RISKS: There are no known risks to your participation in this study. Respect for your privacy will be my priority at all times.

CONFIDENTIALITY AND ANONYMITY: All information will be held private. I will keep written material from the study in a locked filing cabinet at Mamprobi Clinic for five years. You will not be identified by name in any part of this study.

FREEDOM TO WITHDRAW: You may withdraw from the study at any time without consequence to you personally.

FUTURE USE OF DATA: I may present findings from this study at conferences. I may also publish some of the findings. Health issues may be discussed but not at an individual level.

ADDITIONAL CONTACTS:

Ghanaian contact to be determined

Dr. Brenda Cameron – (780) 492-6412

Dr. Kathy Kovacs Burns – (780) 492- 3769

Research participants Verbal Consent

My name is _____. I have talked with the researcher and a clinic nurse about the study titled Intercultural Dialogue: The Call of Africa Lives With Me Still.

I have read or listened to the information letter. I have been able to ask questions about the project. I agree to have the researcher accompany my nurse during my time at the clinic.

I agree to have my health concerns discussed later with my nurse and the researcher_____

I do not agree to have my health concerns discussed later_____

I hereby give my consent to this study.

_____

Participant

_____

Witness

Appendix 3: Information sheet # 3

UNIVERSITY OF ALBERTA

Information Sheet # 3 Edmonton

Intercultural Dialogue: The Call of Africa Lives With Me Still

INVESTIGATOR:
Julie A Gilbert RN, BScN, MN (c)
Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 430-7261

CO-INVESTIGATOR:
Dr. Brenda Cameron PhD, RN
Associate Professor, Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 492-6412

PURPOSE OF THE STUDY: You are being asked to take part in a research study. The purpose of the study is to explore communication between different cultures. We will talk about issues related to health care.

BACKGROUND: Canada is a multicultural nation. In health care settings nurses must communicate with, care for, and understand people of different cultures. By talking with people from different cultural backgrounds, nurses can learn about their own and other's cultural experiences. Through conversations we hope to understand some of the areas that influence communication.

PROCEDURES: You will be invited to:

1. Participate in a conversation of my experiences with intercultural dialogue in Ghana.
2. Share your own experiences with intercultural dialogue in your work with the Sudanese refugee community.
3. Your conversations will be audiotaped and last for up to one hour each. There will be 1 to 3 conversations.

VOLUNTARY PARTICIPATION:

BENEFITS: This study may have no direct benefit for you. I hope to understand better what is required for effective communication between cultures.

RISKS: There are no known risks to your participation in this study. Respect for your privacy will be my priority at all times. You may request no tape-recording at any time.

CONFIDENTIALITY AND ANONYMITY: All information will be held private. I will keep tapes and written material from the study in a locked filing cabinet at the University of Alberta for a period of five years. I will delete your name from all the records. Your real name will not be used. Consent forms will be stored separate from the tapes. I will do my best to keep your identity and information confidential, but because of the small number of participants it may be possible for you to be identified. I will provide you with

the chance to review the data to be sure you are comfortable with how the information is being presented. You can choose to remove any quotes you have made at that time.

FREEDOM TO WITHDRAW: During the conversations you do not have to discuss any subject you do not want to. You may withdraw from the study at any time without consequence to you personally.

FUTURE USE OF DATA: I may present findings from this study at conferences. I may also publish some of the findings.

ADDITIONAL CONTACTS:

Dr. Brenda Cameron – (780) 492-6412

Dr. Kathy Kovacs Burns – (780) 492- 3769

Appendix 4: Consent form #1

CONSENT FORM # 1 – Ghana

Title: Intercultural Dialogue: The Call of Africa Lives With Me Still

INVESTIGATOR:
Julie A Gilbert RN, BScN, MN (c)
Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 430-7261

CO-INVESTIGATOR:
Dr. Brenda Cameron PhD, RN
Associate Professor, Faculty of Nursing
University of Alberta
Edmonton, Alberta,Canada
(780) 492-6412

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect you in any way.	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____		_____
Printed Name		Printed Name

I believe the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator	Date

Appendix 5: Consent form # 2

CONSENT FORM # 2 Mamprobi Clinic Patients

Title: Intercultural Dialogue: The Call of Africa Lives With Me Still

INVESTIGATOR:
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Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 430-7261

CO-INVESTIGATOR:
Dr. Brenda Cameron PhD, RN
Associate Professor, Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 492-6412

Do you understand that you have been asked to be in a research study?	Yes No
Have you read and received a copy of the attached Information Sheet?	Yes No
Do you understand the benefits and risks involved in taking part in this research study?	Yes No
Have you had an opportunity to ask questions and discuss this study?	Yes No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect you in any way.	Yes No
I agree to have my health concerns discussed by my nurse and the researcher	Yes No

This study was explained to me by:_____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____		_____
Printed Name		Printed Name

I believe the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator	Date

Appendix 6: Consent form # 3

CONSENT FORM # 3 Edmonton

Title: Intercultural Dialogue: The Call of Africa Lives With Me Still

INVESTIGATOR:
Julie A Gilbert RN, BScN, MN (c)
Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 430-7261

CO-INVESTIGATOR:
Dr. Brenda Cameron PhD, RN
Associate Professor, Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 492-6412

Do you understand that you have been asked to be in a research study?	Yes No
Have you read and received a copy of the attached Information Sheet?	Yes No
Do you understand the benefits and risks involved in taking part in this research study?	Yes No
Have you had an opportunity to ask questions and discuss this study?	Yes No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect you in any way.	Yes No

This study was explained to me by:_____

I agree to take part in this study.

_____	_____	_____
Signature of Research Participant	Date	Witness
_____		_____
Printed Name		Printed Name

I believe the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Investigator	Date

UNIVERSITY OF ALBERTA

Amaneɛbɔ Krataa # 2 Mamprobi Ayaresabea mu Ayarefoɔ

"Amammerɛ ahodoɔ nkitahodie tebea."

NHWEHWƐMUFOƆ
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Faculty of Nursing
University of Alberta
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(780) 430-7261

NHWEHWƐMUFOƆ BOAFOƆ
Dr. Brenda Camewu PhD, RN
Associate Prof: Faculty of Nursing
University of Alberta
Edmonton, Alberta, Canada
(780) 492 – 6412

ABENSUA NO BOTAE: Meyɛ "nɛɛse" a mefi Canada. Mewɔ Ghana a meresua sɛnea yɛhwɛ nnipa a wɔfiri amammerɛ ahodoɔ mu. Me ne wo nɛɛse no na ɛbɛwɔ ayaresabea ha nnɛ. Mmom, ɛnyɛ me na merebɛhwɛ wo yadeɛ. Nso akyire yi ebia me ne wo nɛɛse no bɛdi w'apɔmuden ho nkɔmmɔ. Ebia yɛbɛkasa afa ɔkwan a yɛbɛtumi afa so ama nnipa a wɔn amammerɛ nyɛ pɛ ho apɔmuden ho nkutahodie ayɛ mmerɛ. Sɛ yɛdi saa nkitahoɔ yi a ɛbɛboa ama yɛasua nnipa apɔmuden ho nimdeɛ pii.

NHYEHYƐE

1. Nɛɛse foforɔ bi bɛkyerɛkyerɛ adesua yi mu akyerɛ wo. Ɔbɛbisa wo ama woatwerɛ anaa woaka sɛ wopene so sɛ me ne wo nɛɛse no mmom mmra wo nkyɛn wɔ ayaresabea ha.

2. Akyire yi, ebia me ne wo nɛɛse no bɛdi nkɔmmɔ afa nneɛma a ɛfa w'apɔmuden ne w'amammerɛ a yɛhuiɛ berɛ a yɛbɛsraa wo no. Nkɔmmɔ a me ne wo nɛɛse no bɛdi no yɛ adeɛ a ɛnkɔ abɔnten mma obiara nte.

3. Sɛ wompɛ sɛ yɛbɛdi w'apɔmuden ho nkɔmmɔ a, ma yɛnhunu. Ɛnneɛ yɛnni saa nkɔmmɔ no.

ATUHOAKYƐ MMOA

MFASOƆ: Ebia wonnya mfasoɔ pɔtee bi mfi saa adesua yi mu. Me na mepɛ sɛ menya nteaseɛ pa bi wɔ nea ehia sɛ yɛyɛ na nnipa a wɔn amammerɛ nyɛ pɛ no bɛtumi adi nkitahoɔ yie.

ASIANE: Sɛ wode wo ho hyɛ saa adesua yi mu a, asiane biara nni hɔ a ɛbɛto wo. Sɛnea ɛbɛyɛ na w'asumasɛm nkɔ abɔnten yɛ adeɛ a ɛhia me na mɛbɔ ho ban nso yie.

BANBƆ A WOWƆ WƆ SAA ADESUA YI MU

Nsɛm biara a ɛbɛpue wɔ yɛn nkitahodie a yɛbɛnya no yɛ adeɛ a mɛbɔ ho ban yie na obiara nhu sɛ ɛfiri wo hɔ. Mede biribiara a mɛtwerɛ afa saa adesua yi ho no bɛsie nnadeɛ adaka bi mu mfeɛ num wɔ Mamprobi ayaresabea. Wo din mpue wɔ adesua yi mu baabiara.

FAWOHODIE A WOWƆ YƐ WOYI WO HO FIRI ADESUA YI MU.

Wobɛtumi ayi wo ho afiri saa adesua yi mu ɛberɛ biara a wopɛ na obiara ntumi nyɛ wo hwee.

NEA DAAKYE YƐDE ADESUA YI BƐYƐ

Ebia mede osuahu ahodoɔ a mɛnya wɔ saa adesua yi mu bi bɛto dwa wɔ nhyiamu ahodoɔ bi ase. Ebia mɛtintim osuahu yi bi wɔ nkrataa mu. Ebia yɛbɛdi apɔmuden ho nsɛm a ɛbɛfiri adesua yi mu ho nkɔmmɔ, nso ɛnyɛ adeɛ a yɛbɛfa no sɛ onipa baako pɛ asɛm. Ebia yɛbɛyɛ adesua yi mu mpɛnsɛnpɛnsɛmu akɔ anim. Sɛ ɛba saa a, akwansrɛ a ehia no yɛbɛsrɛ.

NNIPA A WOBƐTUMI AHU AKYIRE YI

GHANAFOƆ – Mrs. Comfort Adams – Mamprobi Polyclinic.
Mrs. Mary Opare – Head of Department of Nursing, University of Ghana, Legon.

Dr. Brenda Cameron – (780) 492-6412
Dr. Kathy Kovacs Burns – (780) 492-3769

NNIPA A WƆBƐBOA ADESUA YI ANOMU NSƐM A ƐKYERƐ SƐ WƆAPENE SO.

Me din de ----------. Me ne nhwehwɛmufoɔ yi ne nɛɛse bi a ɔwɔ ayaresabea ha adi nkɔmmɔ afa adesua a etire asɛm ne "Amammerɛ ahodoɔ nkitahodie tebea" ho. Makenkan anaa matie krataa a ɛkyerɛ adesua yi mu no mu asɛm. Manya kwan abisa nsɛm afa adesua no ho. Mepene so sɛ mɛma kwan ama nhwehwɛmufoɔ yi ne me nɛɛse abɛsra me wɔ mmerɛ a mewɔ ayaresabea ha nyinaa.

Mepene so sɛ me ne nhwehwɛmufoɔ yi ne me nɛɛse bɛdi m'apɔmuden ho nkɔmmɔ akyire yi ----------

Mempene so sɛ yɛbɛdi m'apɔmuden ho nkɔmmɔ akyire ----------

Magye ato mu sɛ mede me ho bɛhyɛ adesua yi mu.

Ɔyarefoɔ a ɔde ne ho ahyɛ adesua yi mu.

Ɔdanseni

UNIVERSITY OF ALBERTA

MPENESOƆ KRATAA # 2 Mamprobi Ayaresabea mu Ayarefoɔ.

Ammamerɛ Ahodoɔ Nkitahodie Teabea

NHWEHWƐMUFOƆ PANIN
Julie A. Gilbert RN, BScN
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University of Alberta
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(780) 430 – 7261

NHWEHWƐFOƆ BOAFOƆ/ƆHWƐSOFOƆ
Dr. Brenda Cameron PhD, RN
Associate Professor, Faculty of Nursing
University of Alberta
Edmonton, Alberta. Canada.
(780) 492 – 6412

Wote asɛɛ sɛ yɛde wo ahyɛ nhwehwɛmu adesua bi mu?	Aane	Daabi
Woanya **Amaneɛbɔ Krataa** a ɛkyerɛ adesua yi mu no bi akenkan?	Aane	Daabi
Wote mfasoɔ ne asiane a ɛwɔ nhwehwɛmu adesua a wode wo ahyɛ mu yi ase?	Aane	Daabi
Woanya kwan adi adesua yi ho nkɔmmɔ abisa ho nsɛm anaa?	Aane	Daabi
Wote asɛɛ sɛ wowɔ ho kwan sɛ woka sɛ womfa wo ho nhyɛ adesua yi mu anaa wotumi yi wo firi mu berɛ biara a wopɛ? Ɛnhia sɛ wobɛkyerɛ wo sɛ enti na ɛrenha wo wɔ ɔkwan biara so.	Aane	Daabi
Mepene so sɛ menɛɛse ne nhwehwɛmufoɔ no bɛdi nkɔmmɔ afa m'apɔmuden ho.	Aane	Daabi

Nea ɔkyerɛkyerɛɛ adesua yi mu kyerɛɛ me ne _____
Mepene so sɛ mede me ho bɛhyɛ adesua yi mu.

_____ _____
Me nsɛnkyerɛne/agyinahyɛdeɛ Ɔdanseni

_____ _____
Me din Ne din

Megye di sɛ onipa a wayɛ ne nsɛnkyerɛne wɔ krataa yi so te nea ɛwɔ adesua yi mu ase pefee na ɔfiri ɔnoara ne pɛ mu apene so sɛ ɔde ne ho bɛhyɛ adesua no mu.

_____ _____
Nhwehwɛmufoɔ no Nsɛnkyerɛne Ɛda a yɛyɛɛ saa nhyehyɛɛ yi.